A STUDY OF OCCUPATIONAL STRESS IN SELECTED SPECIALTIES IN THE NURSING PROFESSION

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PREFACE

Doctoral research is a joint effort. The degree is awarded to only one, but many good minds and good friends have guided the candidate to the end of one's doctoral journey. This journey has not been without its temporary dead ends and detours, but the trip has been a meaningful one.

The final research, the dissertation, is a stretching exercise with its typical pleasures and pains. It is a necessity to experience this stretching in order to grow through one's life. This research has grown during the past two years.

The dissertation has been tedious, time consuming, a combination of pleasure and pain and occasionally a great source of satisfaction. Once is truly enough. While the researcher readily accepts all responsibility for the present study, including its limitations and deficiencies, grateful appreciation is sincere and long overdue to those who assisted in the development and completion of this project.

To Dr. Betty Abercrombie, whose gentle guidance and ever present friendship has left its mark, so pleasantly, on so many of her flock, I say a heartfelt thank you.

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CHAPTER I

INTRODUCTION

Before discussing stress as an abstract notion, it is imperative to understand that stress is a personal experience. The stress condition is best understood when thought of not as a phenomenon that goes on "out there" in the environment, but as a phenomenon that is created within one's own body. From that personal experience it is possible to better understand what causes stress and to manage its symptoms in a specific and effective manner.[1]

Stress has been defined in numerous ways. There are as many definitions as there are authors who write about it. There is a general tendency to define stress as that physical and emotional experience which results from a requirement to change from the condition of the moment to any other condition. Each individual experiences some degree of stress virtually all of the time. To be experiencing some stress is to be alive; absence of stress would indicate death.[2]

Problems dealing with stress become apparent when there is too much stress, or too much for too long. It is apparent that too much stress for too long can be destructive. Stress is a physical and emotional phenomenon.[3]

As a result of inherent requirements, the nursing profession often provides the nurse with experiences of danger (or stress) as a continuing condition. The danger arises from sickness or injury among patients

for whom they are responsible, or from the effects of inaccurate medication doses, and inaccurate or insufficient information concerning a patient's condition. There is danger for the nurse through other experiences, such as insufficient resources to meet the needs and wants of patients; lack of time to provide needed patient care and attention; and the pressures of having to decide which patient gets what appropriate attention.[4]

The role of the nursing professional is undergoing dramatic expansion relative to the delivery of health care services. Critical care unit nurses are assuming greater responsibility for managing patient care in the acute health care settings. The expanding role of the critical care nurse provides confrontation by both the potential crisis of the patient's condition and the increasing demand for technological excellence. Critical care unit nurses experience stressful events related directly to the individual patient needs and indirectly to the pressures within the highly technical environment.[5]

Accompanying the emergence of specialized hospital units and the changing and expanding role of the nurse in recent years, there has been an increased recognition of the psychological stressors experienced by nursing professionals. In addition to general stress, nurses are subject to increased stress which arises from the physical, psychological, and social aspects of the hospital environment.[6] Within the critical specialty unit, forces such as the technological environment, the patient, patient care, the patient's family, staff personnel relationships, and administrative hierarchy of the hospital contribute to the increased stress level in the nurse. The critical care nurse must be able to successfully manage stress in order to meet and continue to provide high

standards of nursing care.[7] There is a void in the research information concerning stress in selected critical and non-critical care specialties as regards quantitative measures of frequency and intensity of stress incidence.

The field of nursing represents one of the most difficult, demanding, and complex occupations devised by organized society. Not only are nurses responsible for the well-being of the patient, but due to the expansion of medical technology, including the intensive care units, nurses experience the additional pressures of managing a "highly technical environment."[8]

It has been reported in numerous studies that stress is present in the occupational setting. Studies completed on stress and the hospital-based nurse have been largely qualitative through case studies and interviews. Few studies in nursing stress have been quantitative in nature. Research has indicated that the occupational setting of hospital-based nursing has a greater stress potential than others.

Statement of the Problem

The primary purpose of this study was to determine the frequency and intensity of stress in selected specialties in the acute care hospital nursing staff.

Statement of the Hypotheses

The purpose of the proposed study was to test the following hypotheses:

1. There is no significant difference between hospital nurses'

levels of stress with respect to critical or non-critical care unit of specialization within the hospital.

2. There is no significant difference between hospital nurses' levels of stress and the number of years served in the nursing profession.

3. There is no significant difference between hospital nurses' levels of stress and the assigned work shift.

4. There is no significant difference between hospital nurses' levels of stress and the number of professional in-service training courses attended.

5. There is no significant difference between hospital nurses' levels of stress and the size of the unit of care.

6. There is no significant difference between hospital nurses' levels of stress with respect to level of formal education.

7. There is no significant difference between hospital nurses' levels of stress and marital status.

8. There is no significant difference between hospital nurses' levels of stress with respect to age.

9. There is no significant difference between hospital nurses' levels of stress with respect to race.

Definitions of Terms

1. Stress: The nonspecific response of the body to demands made upon it.[9]

2. Distress: The harmful physiological consequences of adaptation.[10]

3. Eustress: The pleasant sensations that may accompany certain stressors (eu- is the Greek prefix meaning "good").[11]

4. Acute Care Hospital: A hospital which is capable of providing a full range of health and medical specialties including the care of those patients whose illness follows a severe or critical course.

5. Critical Care Nurse: Registered professional nurses who have had special preparation in the care of critically ill persons whose physical conditions are unstable and require constant observation.[12]

6. Non-Critical Care Nurse: Registered professional nurses who work in the care of persons whose physical illness is not expected to develop into serious unexpected crises. The activities of non-critical care nurses are somewhat predictable in nature. The need is lessened for constant readiness for unexpected crises.[13]

7. Shift: The working period of time for the hospital nursing staff (7-3, 3-11, 11-7).

Limitations of the Study

This investigation was limited by the following criteria:

1. No attempt was made to control the subjects regarding age, sex, or length of time in nursing.

2. No attempt was made to control the interest or motivation of the subjects.

Delimitations of the Study

1. The subjects to be studied were a selected sample from Baptist Medical Center, Presbyterian Hospital, and Mercy Health Center in Oklahoma City, Oklahoma.

2. The subjects for the study were a selected sample from each of the nurse staffing rosters of the three hospital shifts.

3. The questionnaire was not given to all subjects at the same time.

Assumptions

The major assumptions for this investigation included:

1. The selected samples for this investigation at each hospital were representative of the total population of nurses in the acute care hospital.

2. The Nursing Stress Scale to be administered to the sample was a reliable and valid measure of the levels of stress in the hospital-based nurse.

NOTES

[1]David E. Hartl, "Stress Management and the Nurse," American Nursing Supervisor (1979), p. 91.

[2]Ibid., pp. 91-92.

[3]R. S. Lazaras, Psychological Stress and the Coping Process (New York, 1966), pp. 297-298.

[4]Hartl, p. 92.

[5]Susan L. Oskins, "Identification of Situational Stressors and Coping Methods by Intensive Care Nurses," Heart and Lung (1979), p. 953.

[6]Pamela Gray-Toft, "Effectiveness of a Counseling Support Program for Hospice Nurses," Journal of Counseling Psychology (1980), p. 346.

[7]Oskins, p. 953.

[8]Ibid.

[9]Hans Selye, The Stress of Life (New York, 1978), p. 74.

[10]Ibid., p. xvii.

[11]Dennis Sparks and Janice Hammond, Managing Teacher Stress (Washington, D.C., 1981), p. 9.

[12]Joseph P. Maloney, "Job Stress and Its Consequences on a Group of Intensive Care and Nonintensive Care Nurses," Advances in Nursing Science (1982), p. 32.

[13]Ibid.

CHAPTER II

REVIEW OF LITERATURE

Stress, as defined by Selye, is the nonspecific response of the body to demands made upon it. This response to stress may be both positive and negative. Both psychological and physiological responses to stress help prepare the individual for action which is termed the flight-or-fight syndrome. Neither flight nor fight may be possible in every setting. This could lead to any number of personal adaptations in order to cope with the stress.[1]

The word "stress"--like "success," "failure," or "happiness"--means different things to each individual, so that defining it is extremely difficult, although it has become a part of our daily vocabulary. Is it merely a synonym for distress? Is it effort, pain, fear, fatigue, the need for concentration, or even an unexpected triumph which requires complete restructuring of one's whole life? The answer is yes and no. That is what makes the definition of stress so difficult. Every one of these conditions produces stress, but none of them can be singled out as the single example, since the word applies equally to all the others.[2]

Hoffman stated that:

> Stress affects the whole body. As soon as the perception of stress occurs, individuals immediately respond physiologically, psychologically and socially according to his or her own 'set.' This response is to resolve the stress in some manner: by coping, adapting (effectively or ineffectively) or by permanently retiring (death). All of these processes use body energy and leave some form of residual on the individual (a

> lesson well-learned, a scar, an unhealed wound, a physical illness or disease process).[3]

Stress begins with anxiety, a disturbing situation arising from some kind of imbalance within us. All of us, during each day, experience some kind of threatening condition or disharmony. This anxiety leads to tension. This produces a physical reaction to anxiety. When we are tense, nervous impulses create change in our body. When tension reaches a degree of intensity which has an adverse effect upon the body, stress is present.[4]

Observing stress broadly, Selye pointed out not only that stress is unavoidable, but also that its effects can be positive or negative:

> No one can live without experiencing some degree of stress all the time. You may think that only serious disease or intensive physical or mental injury can cause stress. This is false. Crossing a busy intersection, exposure to a draft, or even sheer joy are enough to activate the body's stress mechanism to some extent. Stress is not necessarily bad for you; it is also the spice of life, for any emotion, any activity causes stress. . . . The same stress that makes one person sick can be an invigorating experience for another.[5]

Stress has a pervasive aspect of living that cannot be avoided. It can be caused by pleasant stimuli as well as unpleasant experiences. Selye labeled the harmful physiological consequences of adaptation as "distress," and called the pleasant sensations that may accompany certain stressors "eustress" (eu- is the Greek prefix meaning "good").[6]

It is important to keep in mind that one person's distress may be another person's eustress. Physical factors and learned responses determine whether an activity is perceived to be pleasant or unpleasant. Interpersonal conflict stimulates some individuals, but is a tremendous source of distress for others.[7]

There is difficulty in understanding how such essentially different things as cold, heat, hormones, drugs, sorrow, and joy could provoke an identical biochemical reaction in the body. However, this is the case; it can be demonstrated, by highly objective quantitative biochemical determinations, that certain reactions are totally non-specific and common to all types of exposure.[8]

Stress is essentially reflected by the rate of all the wear and tear caused by life. Although we cannot avoid stress as long as we are alive, we can learn a great deal about how to keep its damaging side-effects, "distress," to a minimum.[9] Medical research has shown that in many respects the body responds in a stereotypical manner, with identical biochemical changes, essentially meant to cope with any type of increased demand upon the individual. The stress-producing factors, technically called stressors, are different, yet they all elicit essentially the same biological stress response.[10]

Each individual is constantly experiencing some kind of stress. Besides the general stressors of everyday life, from time to time the individual encounters more extreme kinds of stressors.[11] Stress is designed as the body's response to any demand, either mental or physical, made upon it. Stressors are the factors that trigger stress.[12]

From the point of view of its stress-producing or stressor activity, it is unimportant to determine whether the agent or situation each individual faces is pleasant or unpleasant. The important aspect that counts is the intensity of the demand for readjustment or adaptation.[13]

Response to stressors follows a generalized pattern called the general adaptation syndrome (G.A.S.), which includes the alarm reaction stage, the resistance stage, and the exhaustion stage.[14]

The initial alarm reaction stage, like a telephone ringing in the middle of the night, creates a generalized stress arousal in which the whole body is mobilized for fight or flight by the secretion of adrenocorticotropic hormone (ACTH) from the pituitary gland into the bloodstream. The body's level of readiness is low at this point, and no specific organ systems have been affected by the stressor.[15]

When the stressor continues, the body's response enters the second, or resistance, stage, in which the ACTH level drops and a specific adaptation of an organ system or process occurs to help cope with the stressors or to suppress it.[16]

> Messages sent from the nervous system reach the hypothalamus and are relayed to the pituitary and adrenal glands. This pituitary-adrenal axis pumps into the bloodstream hormones that influence heart rate and respiration, inhibit visceral activity, and, in general, prepare the body to cope with the perceived demand. If there is appropriate action to be taken by the individual, mobilization is expressed and arousal diminished. The individual is then able to rest and return to pre-exposure levels. If, however, the extant mobilization is not used to cope in an adequately expressive way, arousal and preparedness continue in the body.[17]

Eventually the organs most frequently aroused may become tired and gradually stop working as they are designed to do.[18]

Despite our adaptation, some stressors may persist and bring about the third and final stage of responses--or exhaustion--in which "adaptation energy," as Selye called it, is used up. At this point the signs of the alarm reaction reappear in increased ACTH levels, but the organ system involved malfunctions or becomes diseased. Death may follow at once, or the work of the diseased system may be transferred to a healthier system, delaying death for a time.[19]

After the initial alarm reaction, the nervous system carries the fight-or-flight message to the vital organs, increasing heartbeats per

minute, decreasing the blood supply to parts of the body where it is not needed immediately, heightening the lung capacity, dilating the pupils of the eyes, and decreasing salivation. The body's response under stress includes many drastic changes in body chemistry. Although these reactions are normal and healthy, and in many cases life-saving, they can lead to major health problems.[20]

It is through the general adaptation syndrome, or G.A.S., that the various internal organs, especially the endocrine glands and the nervous system, help the individual both to adjust to the constant changes which occur in and around the environment and to navigate a steady course toward whatever might be considered a worthwhile goal.[21]

Life is primarily a process of adaptation to the circumstances in which we exist. A constant give-and-take has been going on between living matter and its inanimate surrounds, between one living being and another, ever since the dawn of life in the prehistoric oceans. Through the constant interplay between mental and bodily reactions, we have the power to influence this adaptation.[22]

Psychosocial stress has become a common element in modern life. Now that many of the physical stressors have been eliminated from our environment, the major stressors come from how we perceive and relate to our environment. A variety of psychosocial stressors exist that may cumulatively affect our physical and mental health, although in small doses none of them may be felt as more than passing annoyances. Collectively, these stressors arise from our emotional response to the world as we perceive it.[23]

Stress that goes unnoticed or is not dealt with at the time of its initial occurrence can often create a fertile place for subsequent stress-

producing situations to grow--"often magnified by the original unresolved stress."[24] When the energy inherent in the stress response does not become channeled outwardly, stress develops a negative aspect. "It is this misdirection of energy, rather than the stress itself, which can be detrimental. The body turns on itself, so to speak, and in doing so, may cause serious physical and emotional disturbances."[25]

Problems arising within any environment may pose potential threats. According to Lazarus, threat is defined as the individual's anticipation of future harm by a stressor. Problems are a potential threat in that they can block goals and values in the individual and eliminate the effectiveness of a capable professional.[26]

Occupational stress is generally seen and measured by individual reactions to situations perceived consciously or unconsciously as threatening. People react based on personal predisposition and in a vocational context. Job stress may be defined as the condition in which some factor, or combination of factors, at work interacts with the worker to disrupt his pyschological and physiological homeostasis. The factor or combined factors at work are generally called job stressors, and the disruption of homeostasis is often called job-related strain. The concept of the factors of the job interacting with the worker is significant. It is quite clear from informal observation, as well as controlled research, that individuals respond to identical job situations in very different ways.[27]

Most people try to cope with job stress either passively, by working harder, or actively, by changing circumstances and environment. In a therapeutic mode, one may consider that if a person knows beforehand that a stress situation is developing, he can often take steps to mediate

that stress. Fear of consequences is excellent motivation to deal with stress, especially in situations of overload, reorganization, or technological change. Since role conflict or ambiguity are seldom foreseen, prior successful experience or knowing someone with experience, as in a professional relationship, can be most helpful in the mediating effects of the stressors.[28]

Michaels stated that hospitals, in general, are stressful places in which to work. The stressful aspect involves the carrying out of tasks, which by ordinary standards, are disgusting, distasteful, and frightening.[29]

Gray-Toft suggested that three signs of negative stress on the job may be an increase in job dissatisfaction, an increase in self-reported stress, and an increase in staff turnover in nursing personnel.[30] Storlie suggested that burnout is also a stressor. The risks for burnout are not equal among all types of nurses. Those working with the terminally ill, on cancer units, and on burn units are especially vulnerable to burnout. "One needs but look at the habitat in which they work to understand why. The setting in itself is a major stress for the nurse."[31]

Gray-Toft found in the field testing of the Nursing Stress Scale that nursing stress has an adverse effect upon patient care as well.[32] Nursing stress scores were positively correlated with trait anxiety among hospital nursing staff. The scores were found to be inversely correlated with job satisfaction. The stress scale differentiated units within the hospital and groups of nurses that appeared to be experiencing burnout, as evidenced by high rates of nursing personnel turnover.[33]

During the last 20 years, intensive care units have become an essential part of most general hospitals. Older institutions have remodeled existing space to include them. No new hospital is now designed without the critical care units. Their value in the treatment of the patient who is critically ill has been documented. The modern critical care unit is a result of the application of modern electronic technology to the observation and treatment of patients.[34] Over the last 15 years a great deal has been written concerning these critical care units and their effects on patients and families, on hospital costs, and on patient care. Little has been written about the effects of stress on the major providers of critical care services--the nurses.[35]

Caring for patients is basic to the nursing role. However, it may create an extra stressful situation if the patient is terminally ill or at the peak of a crisis. Compounding this stress is a belief common among nurses that their job is to preserve life. This failure to preserve life is seen as failure to do one's job. The result may be uneasiness, tension, or "even unconscious anger at the patient, as though his lack of response to treatment were deliberate."[36]

Strauss noted that there are positive aspects to nursing in an intensive care facility.[37] Eustress is the term used by Selye to identify the positive aspects of stress.[38] Holsclaw related that the high morale gained from saving lives and seeing acutely ill patients recover is a positive aspect of stress. Nurses are seen as "key" persons in the intensive care unit and often see themselves as the elite of the hospital. There is an an increased closeness among the ICU staff due to the interaction with physicians. The work is exhilarating and challenging, not "run of the mill."[39]

Selye pointed to the negative aspects of stress as distress, and used this term to identify those aspects which tend to be detrimental to one's well-being if experienced in sufficient numbers.[40] Constant exposure to suffering, illness, and death is an occupational problem of nursing matched by few other groups. The overall behavioral effects of such stress are "nursing dropouts, a high incidence of absenteeism due to minor illness, the exacerbation of emotional problems, marital conflicts, complaints of job dissatisfaction, and vague somatic complaints."[41]

For the nurse working in an intensive care unit, the problem of stress is thought to be even more pronounced. The intensive care unit is a highly charged, specialized environment, specifically designed for the treatment of seriously ill patients.[42]

A high level of competency is necessary to manage complex equipment such as monitors, ventilators, and computers. The demand for quick and accurate decision making and flawless judgment is present at all times in the critical care setting. The nurses care for patients in the critical care unit during an eight-hour shift. The physician may be in the unit for one hour or less during each shift. This produces additional emotional stress which may lead to a number of disturbing attitudes and feelings.[43]

A study by Jacobson indicated that neonatal intensive care units are stressful, but the stressors are more likely to be personal and psychological rather than concrete and external.[44] The nurse's life outside the job can be filled with specific events and certain on-going conditions that produce feelings of stress. Holmes and Rahe have developed a list of changes and life events in their Social Readjustment Scale that are often perceived as a danger to one's well-being. These scale

items include divorce, death of a family member, marriage, change of residence, and serious illness.[45] Hartl suggested that on-going conditions such as unusual hours at home due to shift hours, long drives to work each day, problems with children, and a seemingly endless upward spiral of living costs frequently induce personal distress as well.[46]

Oskins found some important deficiencies in stress management through a continuing education questionnaire. The sample of 79 intensive care registered nurses indicated that 40.5 percent had never finished a course in death and dying; 60.5 percent showed no participation in a course dealing with stress; and 64.5 percent had never been involved in a course dealing with crisis intervention. Oskins found that this deficiency in stress education indicated a definite need for continuing education in stress management for nurses.[47]

There is a need for nursing service to "clarify the sources of stress that exist in the clinical working environment."[48] Once the sources of stress are established, more definitive investigations may be done regarding the various influences on the nurse's anxiety level.

Summary

A great body of literature exists on the general subject of stress. The identification of stress as a part of certain occupations has been documented as well. This occupational stress category with high stress potential would include the hospital nurse. Certain nursing specialties are reported to have greater stress potential than others.

The studies completed on stress and the hospital-based nurse have been largely qualitative through case study and interview techniques. Little research has been completed comparing the stress levels in

critical/non-critical care nursing specialties. There is a void in the research information concerning stress in selected critical and non-critical care specialties as regards quantitative measures of frequency and intensity of stress incidence.

NOTES

[1]Hans Selye, The Stress of Life (New York, 1978), p. 74.

[2]Hans Selye, Stress Without Distress (Philadelphia, 1974), p. 26.

[3]Rachel Hoffman, "Stress and the Critical Care Nurse," Supervisor Nurse (1981), p. 21.

[4]Dennis Sparks and Janice Hammond, Managing Teacher Stress (Washington, D.C., 1981), p. 9.

[5]Selye, The Stress of Life, p. xv.

[6]Sparks and Hammond, pp.10-11.

[7]Selye, Stress Without Distress, p. 29.

[8]Sparks and Hammond, p. 11.

[9]Selye, The Stress of Life, p. xvii.

[10]Selye, Stress Without Distress, p. 26.

[11]Selye, The Stress of Life, p. 17.

[12]Ibid., p. xvi.

[13]Selye, Stress Without Distress, p. 28.

[14]Hans Selye, The Story of the Adaptation Syndrome (Montreal, 1952), p. 3.

[15]Hans Selye, "The Stress Syndrome," American Journal of Nursing (1965), p. 97.

[16]Ibid., p. 98.

[17]Sparks and Hammond, p. 10.

[18]Selye, "The Stress Syndrome," p. 98.

[19]Ibid., p. 99.

[20]Selye, The Stress of Life, p. 10.

[21]Ibid., p. xv.

[22]Ibid., p. xvi.

[23]Erik Gunderson and Richard H. Rahe, eds., Life, Stress and Illness (Springfield, 1974), p. 8.

[24]David E. Hartl, "Stress Management and the Nurse," American Nursing Supervisor (1979), p. 91.

[25]Ibid.

[26]R. S. Lazarus, Psychological Stress and the Coping Process (New York, 1966), pp. 297-298.

[27]Alan A. McLean, ed., Occupational Stress (Springfield, 1974), p. 15.

[28]Ibid., p. 7.

[29]Davida R. Michaels, "Too Much in Need of Support to Give Any?" American Journal of Nursing (1971), p. 1932.

[30]Pamela Gray-Toft, "Effectiveness of a Counseling Support Program for Hospice Nurses," Journal of Counseling Psychology (1980), p. 347.

[31]Frances J. Storlie, "Burnout: The Elaboration of a Concept," American Journal of Nursing (1979), p. 2109.

[32]Pamela Gray-Toft and James G. Anderson, "The Nursing Stress Scale: Development of an Instrument," Journal of Behavioral Assessment, III (1981), p. 22.

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[34]Donald S. Kornfeld, "Psychiatric Problems of an Intensive Care Unit," Medical Clinics of North America (1971), p. 1353.

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[36]Rosemary Scully, "Stress and the Nurse," American Journal of Nursing (1980), p. 913.

[37]Scully, p. 913.

[38]Anselm Strauss, "Intensive Care Unit: Its Characteristics and Social Relationships," Nursing Clinician (1968), p. 12.

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[40]Selye, The Stress of Life, p. 74.

[41]Joseph P. Maloney, "Job Stress and Its Consequences on a Group of Intensive Care and Nonintensive Care Nurses," Advances in Nursing Science (1982), p. 31.

[42]Ibid.

[43]Daniel Gardner, Zane D. Parzun, and Nancy Stewert, "The Nurse's Dilemma: Mediating Stress in Critical Care Units," Heart and Lung (1980), pp. 103-104.

[44]Sharol P. Jacobson, "Stressful Situation for Neonatal Intensive Care Nurses," The American Journal of Maternal Child Care (1978), p. 150.

[45]T. H. Holmes and R. H. Rahe, "The Social Readjustment Rating Scale," Journal of Psychosomatic Research (1967), pp. 213-218.

[46]Hartl, p. 93.

[47]Susan L. Oskins, "Identification of Situational Stressors and Coping Methods by Intensive Care Nurses," Heart and Lung (1979), p. 956.

[48]Maloney, p. 41.

CHAPTER III

METHODS AND PROCEDURES

Methodology

The primary purpose of this study was to determine the levels of stress in selected specialties in the acute care hospital nursing staff. The population consisted of nursing personnel from each of the three acute care hospitals in the greater metropolitan area of Oklahoma City, Oklahoma. The three hospitals used were: (1) Baptist Medical Center, (2) Presbyterian Hospital, and (3) Mercy Health Center. While these hospitals varied in size, number of nursing staff, licensed patient beds, equipment, and number of in-service training programs, there was one fundamental likeness: the nursing personnel were licensed by the State of Oklahoma to administer patient care.

Subjects

The sample consisted of 24 nurses from each hospital for a total of 72 nurses. Eight subjects from each of the three shifts were selected by the head nurse. Those eight nurses from each shift were equally divided between critical and non-critical care nursing specialties.

Throughout the study every effort was exerted to maintain and protect the anonymity of the respondents on the questionnaires and interviews. Every individual tested and interviewed was made aware of the confidentiality of the information being given by the subjects.

Procedures

The following procedures were followed in collecting the data regarding stress in the acute care hospital nursing personnel:

1. The quantitative instruments were identically explained and administered to each of the subjects.

2. The researcher asked each of the 72 subjects selected for the study to fill out a demographic questionnaire.

3. The researcher immediately administered the 34-item Nursing Stress Scale to each of the selected subjects. One-half of the subjects were chosen from critical care units and the remaining one-half were selected from non-critical care units within the hospitals.

4. The researcher conducted a five-question interview with six selected subjects from each of the three hospitals in order to provide further information about certain aspects of stress which was not ascertained in the Nursing Stress Scale. In conducting the five-question interviews, the researcher recorded on tape each of the responses provided by the critical care and non-critical care nurses in an attempt to discover common characteristics associated with each of the interviews. In addition, extensive notes were kept about observations that were made during the administering of the quantitative data.

Each of the 18 interviews were conducted in the hospital during the nurses' work shift in order that each nurse would feel less threatened by the interview process and would respond more openly. As far as can be determined by the researcher, the natural work environment of the unit did assist in breaking down interview barriers that may not have been overcome in a more unfamiliar setting. Further, the researcher attempted to gain the confidence of each before the interview process

began. This was accomplished by engaging in brief conversation with each nurse before the interview. Time away from nursing duties was limited. All gave up break time voluntarily to assist in the research and respond to the five questions during the interview. Pressing duties may have shortened the length of each answer. However, the researcher observed a sign of commitment on the part of each of the nurses interviewed to give an honest and accurate answer. A few were somewhat reluctant, at first, to be recorded on tape for fear that their comments might in some way be misused. Once they became confident tha strict anonymity would be adhered to by the researcher, they relaxed and began to talk candidly.

Throughout the interviewing process, the researcher remained conscious of considerations set forth by Young when she stated:

> Interviewing is not a simple two-way conversation between an interrogator and informant. Gestures, glances, facial expressions, pauses often reveal subtle feelings. Voice inflections and halting statements can be as much a part of the interplay between conversing persons as their questions and answers.[1]

In dealing with the area of focused interviews, Young has also stated: "Although the whole situation is carefully structured and the major areas of inquiry mapped out, the interviewee is given considerable freedom to express his definition of a situation that is presented to him."[2]

During the interview process, close attention was paid to the "body language" and "voice inflections" expressed by the nurses. Further, even though the questions were structured and designed to gather specific information, the nurses were allowed to expand upon the questions with whatever information they wanted to provide.

Finally, the task of going into the "real world" of the hospital nurse to gather information was generated, in part, after having read

the extensive work of Terkel.[3] To see it as it "really is," as told by those who "really do it," does broaden one's research perspective.

5. The interviews were conducted within one week of the administration of the Nursing Stress Scale.

6. One subject was selected from a non-critical area of nursing and one subject from a critical area of nursing in each of the three shifts for a total of 18 from the three hospitals used for the interviews.

7. The interviews were recorded in order to have an accurate account of the responses. Complete transcripts of all interviews are found in Appendix B.

8. The Nursing Stress Scale and the interviews were conducted during the first four hours of each shift.

9. No weekend personnel rosters were utilized in an attempt to maintain the consistency of full-time nursing personnel selected for the study.

Instrumentation of the Study

The Nursing Stress Scale[4] consists of 34 items that describe situations that have been identified as causing stress for nurses in the performance of required duties. It provides a total score that measures the frequency of stress experienced by nurses in the hospital environment. Test-retest reliability as well as four measures of internal consistency indicate that the Nursing Stress Scale is reliable. The test-retest coefficient for the total scale was 0.81. The four measures of internal consistency which were obtained were: a Spearman-Brown coefficient of 0.79, a Guttman split-half coefficient of 0.79, a coefficient alpha of

0.89, and a standardized item alpha of 0.89. All four measures indicate a satisfactory level of consistency among the items.[5]

Validity was determined by correlating the total score from the Nursing Stress Scale with measures of trait anxiety, job satisfaction, and state anxiety, which are important criteria to which stress is theoretically related. In order to validate the Nursing Stress Scale, trait anxiety was measured with the IPAT Anxiety Scale Questionnaire, state anxiety with the potent negative affect component of the Affect Rating Scale and the job satisfaction aspect with the Work Subscale of the Job Description Index. The product moment correlations of each of the three measures with the total score from the Nursing Stress Scale revealed a positive correlation with trait anxiety (IPAT) and state anxiety (ARS), $P < 0.01$ and an inverse correlation with job satisfaction regarding frequency of stress.[6]

The frequency measures on the Nursing Stress Scale were designed to indicate how often the situation was stressful for the participating subjects. To identify frequency scores for each of the nurses on the Nursing Stress Scale, Figure 1 indicates the range of possible scores from low to high. This range is based upon the 34 items with possible responses from 1 to 4 per item.

Figure 1. Range of Frequency Stress Scores

In order to gain additional insight into the dimension of stress in the hospital-based nurse, the researcher added the aspect of intensity of stress to the existing frequency of stress scale. Intensity of stress refers to how strong the stress is on the subject when it does occur.

The intensity stress scale portion of the Nursing Stress Scale has no validity or reliability statistics (created specifically for this research project); however, there is every reason to believe that by using the same validated 34 items of the Nursing Stress Scale and utilizing a scale from one to five which has been used in many other studies, relevant information can be ascertained.

Figure 2 diagrams the range of intensity stress scores for the subjects on the Nursing Stress Scale. The range from low to high is based upon the 34 items with possible responses from one to five for each item.

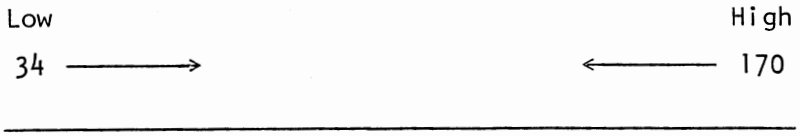

Figure 2. Range of Intensity Stress Scores

Nine nominal independent variables ([1] age, [2] race, [3] highest degree, [4] marital status, [5] years in nursing, [6] unit of employment, [7] unit size, [8] work shift, and [9] in-service training courses] were compared with each dependent variable ([1] frequency of stress, [2] intensity of stress) yielding 18 analysis of variance values (F-values).

All alternate hypotheses were assumed to be open-ended since the direction could not be predicted. Therefore, a two-tailed test of significance was administered.

NOTES

[1]Pauline V. Young, Scientific Social Surveys and Research, 4th ed. (Englewood Cliffs, N.J., 1966), p. 214.

[2]Ibid., p. 219.

[3]Studs Terkel, Working (New York, 1974), p. 12.

[4]The Nursing Stress Scale was developed in 1981 by Pamela Gray-Toft, Department of Medical Research, Methodist Hospital of Indiana, Indianapolis, Indiana, and James G. Anderson, Department of Sociology and Anthropology, Purdue University, West Lafayette, Indiana.

[5]Pamela Gray-Toft and James G. Anderson, "The Nursing Stress Scale: Development of an Instrument," Journal of Behavioral Assessment, 3 (1981), p. 22.

[6]Ibid., p. 21.

CHAPTER IV

RESULTS AND DISCUSSION OF RESULTS

The primary purpose of this study was to determine the frequency and intensity of stress in selected specialties in the acute care hospital nursing staff. This chapter includes the results of the statistical analysis of the data collected from the use of the Nursing Stress Scale, and qualitative results from the five structured interview process.

Quantitative Results

The results of the frequency of stress hypotheses were as follows:

1. There is no significant difference between hospital nurses' levels of stress with respect to critical or non-critical care unit of specialization within the hospital. Accepted.

2. There is no significant difference between hospital nurses' levels of stress and the number of years served in the nursing profession. Accepted.

3. There is no significant difference between hospital nurses' levels of stress and the assigned work shift. Accepted.

4. There is no significant difference between hospital nurses' levels of stress and the number of professional in-service training courses attended. Accepted.

5. There is no significant difference between hospital nurses' levels of stress and the size of the unit of care. Accepted.

6. There is no significant difference between hospital nurses' levels of stress with respect to level of formal education. Accepted.

7. There is no significant difference between hospital nurses' levels of stress and marital status. Rejected.

8. There is no significant difference between hospital nurses' levels of stress with respect to age. Rejected.

9. There is no significant difference between hospital nurses' levels of stress with respect to race. Accepted.

The results of the intensity of stress hypotheses were as follows (see Table 1):

1. There is no significant difference between hospital nurses' levels of stress with respect to critical or non-critical care unit of specialization within the hospital. Accepted.

2. There is no significant difference between hospital nurses' levels of stress and the number of years served in the nursing profession. Accepted.

3. There is no significant difference between hospital nurses' levels of stress and the assigned work shift. Accepted.

4. There is no significant difference between hospital nurses' levels of stress and the number of professional in-service training courses attended. Accepted.

5. There is no significant difference between hospital nurses' levels of stress and the size of the unit of care. Accepted.

6. There is no significant difference between hospital nurses' levels of stress with respect to level of formal education. Accepted.

7. There is no significant difference between hospital nurses' levels of stress and marital status. Accepted.

TABLE I

MEANS, F-VALUES, AND PROBABILITY FACTORS FOR HOSPITAL-BASED NURSES ON INTENSITY OF STRESS AS IT RELATES TO EACH INDEPENDENT VARIABLE (TOTAL NUMBER OF SUBJECTS = 72)

Variable	N's	Means	F-Value	Probability
Age			6.309**	0.0030
20-29	33	112.7273		
30-39	26	97.8077		
40-49	13	90.6154		
Race			0.256	0.6142
Minority	8	107.2500		
White	64	102.8794		
Degree			1.317	0.2760
ANS	22	80.5455		
Diploma	17	78.4706		
BA/BS/BSN	24	80.7500		
LPN	9	80.5556		
Marital Status			0.803	0.4964
Single	19	107.4737		
Married	36	99.4722		
Divorced	12	109.1667		
Widowed	5	101.6000		
Years in Nursing			1.826	0.1688
0-5	33	107.0909		
6-10	20	105.2000		
Over 10	19	94.8947		
Hospital Unit			0.162	0.6887
Critical	36	104.4444		
Non-Critical	36	102.2500		
Size of Unit			0.298	0.7434
0-10	22	105.3182		
11-20	36	103.7222		
Over 20	14	99.2857		
Work Shift			0.647	0.5268
7am-3pm	24	104.2917		
3pm-11pm	24	99.3200		
11pm-7am	24	106.7391		
In-Service Courses			2.013	0.1203
10 and under	25	111.0400		
11-20	16	97.9375		
21-50	26	97.7692		
Over 50	5	111.2000		

** Hypothesis significant.

8. There is no significant difference between hospital nurses' levels of stress with respect to age. Accepted.

9. There is no significant difference between hospital nurses' levels of stress with respect to race. Rejected.

Table II displays the mean differences for categories of age as they relate to intensity of stress. It can be seen that the greatest significant difference lies between the 20-29 and the 40-and-over groups. Scheffe's post hoc least significant difference test also revealed a significant difference between the categories of 20-29 and 30-39. No significant difference was ascertained between the 30-39 and 40-and-over groups.

TABLE II

MEAN DIFFERENCES FOR AGE AND INTENSITY OF STRESS

Groups	Means	20-29 112.7273	30-39 97.8077	40 and Over 90.6154
20-29	112.7273	---	14.9196*	22.1119**
30-39	97.8077	14.9196*	---	7.1923
40 and Over	90.6154	22.1119**	7.1923	---

*($p < .05$).

**($p < .005$).

The null hypothesis for frequency of stress and race was also rejected ($F = 5.466$, $p < .05$). Table III reflects that minority nurses

TABLE III

MEANS, F-VALUES, AND PROBABILITY FACTORS FOR HOSPITAL-BASED NURSES ON FREQUENCY OF STRESS AS IT RELATES TO EACH INDEPENDENT VARIABLE (TOTAL NUMBER OF SUBJECTS = 72)

Variable	N's	Means	F-Value	Probability
Age			1.250	0.2928
20-29	33	82.8788		
30-39	26	77.0769		
40 and over	13	79.2308		
Race			5.466**	0.0223
Minority	8	90.8750		
White	64	78.7813		
Degree			0.097	0.9612
ANS	22	80.5455		
Diploma	17	78.4706		
BA/BS/BSN	24	80.7500		
LPN	9	80.5556		
Marital Status			4.622**	0.0053
Single	19	79.7895		
Married	36	75.6389		
Divorced	12	91.0833		
Widowed	5	87.4000		
Years in Nursing			0.038	0.9627
0-5	33	79.6970		
6-10	20	80.1500		
Over 10	19	80.8421		
Hospital Unit			0.114	0.7367
Critical	36	80.6944		
Non-Critical	36	79.5556		
Size of Unit			0.140	0.8696
0-10	22	81.4545		
11-20	36	79.6667		
Over 20	14	79.2143		
Work Shift			2.302	0.1077
7am-3pm	24	78.4167		
3pm-11pm	24	77.0800		
11pm-7am	24	85.2174		
In-Service Courses			0.433	0.7299
10 and under	25	82.5200		
11-20	16	77.5000		
21-50	26	79.7308		
Over 50	5	78.6000		

** Hypothesis significant.

experienced significantly greater frequency of stress than did white nurses. The mean values for minority nurses was 90.875. A mean of 78.7813 was determined for white nurses. The eight respondents in the minority category were a combination of six blacks, one American Indian, and one Hispanic American.

When marital status was considered as an independent variable regarding frequency of stress, Table III reflects that the null hypothesis was rejected ($F = 4.622$, $p < .01$). It was determined that the greatest frequency of stress was experienced by the divorced category with a mean of 91.0833. The lowest level of stress was found in the married category with a mean of 75.6389. Therefore, the significant difference was determined to exist between these two groups of nurses. No significant difference was found between the other categories of marital status with regard to frequency of stress.

Although 15 of the null hypotheses in this study were accepted after applying the statistical process of one-way analysis of variance, further scrutiny of the tables found in this chapter reveals some interesting trends. It is the belief of the researcher that what is revealed by the trends in this study may be as important to understanding the findings as in those areas where statistical significance was determined.

The statistical analysis and findings in this chapter have been presented without elaboration. Further explanation of all of the findings are presented in Chapter V.

Qualitative Results

The following responses were made by the nurses during the interview process. Following each of the interview questions, a general

review of the responses made by the nurses is presented.* When the term "common" or "majority" response is used, it indicates approximately 90 percent agreement of all of the nurses interviewed on a given question.

1. Q: In which unit are you presently working?

A: The research design specified that one nurse from each shift, both in critical care and non-critical care, would be interviewed. This pattern was followed at each of the three hospitals utilized in the study. This resulted in a total of 18 nurses, 9 of which were from critical care areas and 9 from non-critical areas within the hospital. Interviewees were all nurses on duty during their regular shift who had volunteered to take the Nursing Stress Scale and the Demographic Questionnaire. The interview required additional time from their nursing duties. Each nurse gave her time readily when duties permitted a break.

Q: Is this the unit of your choice?

A: The majority of responses indicated that their present nursing specialty and unit were their choice of all units in the hospital. The non-critical care nurses were unanimous in their expression of satisfaction with the unit in which they were presently working. As one non-critical nurse put it:

> I like working in a non-critical specialized area. I enjoy the variety. I feel that I am in the mainstream of the hospital in the medical/surgical unit.

The reasons were varied as to the choice of unit. Length of time as a nurse appeared to have a bearing on the choice of non-critical care specialties. The nurses who had been practicing for a number of years, and whose who were fresh out of nursing school, were in the majority of those

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*Anonymity of the nurses and hospitals will be respected relative to the responses provided.

who preferred non-critical care. One young nurse stated:

> This is my unit of choice for the present time. I would like to get into one of the critical specialties after I get a little more seasoned. I have not been a nurse long, just six months, and I'm not personally ready for a critical unit yet.

A seasoned nurse who is close to retirement expressed her preference in these words:

> Yes, I like this unit. This is the easiest duty I have had in my years as a nurse. After 35 years, and at this time in my life, it is perfect for my needs.

Eight of the nine critical care nurses were working the unit of their choice. The reasons were many and varied but a common type of response was discernible. One nurse stated:

> Yes. I'm not saying the nurses on the floor don't have a needy job to do because they have and it is impossible to do without them, but after a while it gets so humdrum. I loved the people but I somehow felt that I had lost my nursing. I do not feel that way behind these doors.

As another nurse put it:

> I had worked in other units in the hospital for about six or seven years and I quit feeling like a nurse out there. I was a real good waitress and I could give a lot of meds and a lot of pills but down to earth nursing you just don't get out there. So, I came in here very frightened. I had never worked intensive care before. In here there is a daily challenge. I don't think one works critical care long if it's not to her liking. You have to be committed to it.

The only dissatisfied nurse interviewed in the critical care area expressed her feelings in this way:

> I would like to say yes, but I'm in the process of changing to the new Neonatal I.C.U. I move to that unit in three weeks. I have been in this particular unit for five years and I have enjoyed it, but I do need a change. It has been my first choice for five years. I am looking forward to the change. I haven't been excited in a long time. I have been reading and walking by the nursery and staring and thinking that I will soon be there. I'm going to enjoy it, I think.

The only nurse interviewed in critical care who was not working in the unit of her choice was moving to another critical care specialty.

2. Q: What hours are you working?

A: The respondents were evenly divided between the three traditional shifts in hospital nursing. There were six nurses interviewed from each of the hospitals; three from critical care units and three from non-critical care units. There were a total of nine critical care nurses interviewed and nine non-critical care nurses.

Q: Are you working the shift of your choice?

A: Of the 18 respondents, 15 were working the shift of their choice. Those 15 who were pleased with their shift assignment had the following comments regarding their reasons for their shift choice:

> It is important for me to spend as much time with my children as possible, and the 11-7 shift allows me to do so.
>
> At the moment it works out well. I have a small son and that way I can drop him off at the baby sitter at 2:30, and I don't have to leave him at the baby sitter very long. My husband picks him up and cares for him in the evening.
>
> I have 18 years of night duty and that is why I am here in this position. Who wouldn't prefer 7-3? After 18 years, I took this position to become a day person again.
>
> I prefer the sanity of the 11-7 shift. This shift also fits into my life style better than the others.
>
> The quiet, and sanity, the lack of visitors, the ability to get my work done and leave on time--all of these reasons, I guess.
>
> Of all the shifts this one suits my needs and gives me the greatest satisfaction. These patients often cannot sleep and I enjoy spending quality nursing time with them at night.

The three nurses interviewed who were not pleased with their shift had the following reasons for being dissatisfied:

> No, but when you are new you have to take the openings where you can find them. I am single and the 11-7 shift does not contribute to my life style at the present time--I don't enjoy sleeping my days away.
>
> I would really prefer to be a regular on the 7-3 shift. I don't like to tackle the parking lot at night.
>
> I do not like working nights. I will work days just as soon as I can work into a spot on the unit and I hope it is soon.

The three nurses who were dissatisfied each stated that they preferred the 7-3 shift, but it was the difficult one in which to find an opening. The majority of the respondents stated that they did not like weekend duty on any shift, but were required to work weekends, occasionally. Some were scheduled to work every other weekend and stated that they felt additional stress when this happened.

3. Q: Was the nature of the patient illness or the possibility of serious complications or death a major factor in your choice of hospital units?

A: For various reasons which were individual for each nurse, the nature of the illness or the seriousness of the complications was an important factor. Fifteen of the eighteen nurses felt very strongly that this factor was very important in their choice of hospital unit in which to work. The job satisfaction factor was very evident in many of the interviews. The way in which they sought and satisfied that need for self-satisfaction varied somewhat. The need for meaningful nursing duties became more strongly evidenced in the critical care nurse during the interviews and during the filling out of the questionnaires.

Two of the responses to this question point to the needs to be met by non-critical care nurses. They made the following comments:

> Yes. My husband just died seven months ago following a serious illness. I did not want to work intensive care. I had not worked for two years and I came back just three months ago.

> I don't want to deal with any really serious complications right now. At one time the challenge was what I wanted. I felt the need to prove myself and appear competent to others. Now, I know what I can do and I am satisfied to do that well and let the younger nurses find their stride.

The intensive care unit nurses were very verbal about their feelings in this area. They seemed to all need a challenge in their daily

work routine. Several of the intensive care nurses shared their thoughts in the following ways:

> I have not learned all the possible information in this unit. I know that I could advance in this unit but I am not interested. I need to grow and to change. When there is plenty of opportunity to grow and you don't continue to grow, it's time to get out. I am changing units soon. The thing that keeps me in critical areas is that I feel that you can give better patient care and the staffing is usually such that you can. I don't have to worry about ten patients, I just have two or three at the most and I feel like I can do a good job.
>
> Yes. I just had an interest in coronary care experience, one that I had never had before. I have come to enjoy this experience and really like to work with coronary care patients. Everything associated with coronary care patients is so specialized that it has just become my first love. That is the number one medical problem in the United States.
>
> Not the death. My main reason for choosing I.C.U. is that I like fast paced nursing. I like challenges all the time and I guess those come from the serious illnesses. It is never routine.
>
> Yes. I think that the more critical the patient, the more challenging my job is to me. I like the challenge. I also like the response I get from my patients and from myself. It is gratifying when something happens and I am able to help them.

Intensive care nurses seemed to verbalize rather well that they needed to serve and to be challenged. They seemed to feel that what they were doing was very important in many cases was more important than what was being done by non-critical care nurses.

4. Q: What factors of your job do you feel create the most stress for you?

A: Although this question received an excellent response from each interviewee, there was not a clear cut majority among the factors to be discerned from the myriad of responses. Of the 12 specifically identifiable stress factors, 5 received strong comment. Those five stress factors were: personalities, lack of communication, too little time or staff, families of patients, and death.

Several comments were made regarding personality problems and conflicts. The comments included:

> There are always personalities and you have to work around those. You can't try to make everybody like you or like to work with you. You just have to endure it.
>
> Personalities. Jealousies on the unit really get to me. It seems to interfere with my ability to relax at times, and put first things first.

From the notes taken during the administering of the Nursing Stress Scale, the researcher adds:

> The social atmosphere in this unit is so thick you can cut it with a knife. Some days it is so bad that it has to get better; there is no other way to go.

The close proximity of the nurses while performing many of their duties behind the nurses' station is extremely tight. Lounges are often very small and crowded. Without the tensions, anxieties, and job stressors, these small working areas could be a problem. Personal space is just non-existent. Communication problems of all types were expressed by the interviewees. Some of the problem areas were:

> Communication problems with the doctors is often stressful.
>
> We have emergency situations when there is not a doctor available and we don't have any standing order to go ahead and do something; that is the biggest stress. Certain doctors create a stressful situation because they do not like for you to suggest things and they seem to get defensive about it. This may be because you have hit on something that they were not aware of.
>
> On this shift we have less contact with families and even with physicians. Sometimes we have to call them at home, and that can be stressful. The girls on the day shift complain a lot about some of the doctors. They do a lot of squawking about what the doctors said and what he insinuated. We are spared that on this shift.

One very frustrated acute coronary care nurse shared her thoughts in this way:

> I think long-term patients that we have for weeks and weeks at a time. They don't seem to get any better. I wonder what we as nurses could do in conjunction with what the doctor is doing, maybe to speed up their recovery. It bothers me when I come back week after week and that same patient is still there, and there is no significant change. It is very frustrating and stressful. It really bothers me to see the ones with bright, alert eyes go down as they stay in the unit. As time passes the condition slowly deteriorates. What can we do to save that patient that we are not doing? What could have been done when they first came in to prevent their going downhill?

After the regular taped interview was concluded with the nurse quoted above, her following comments were hand written by the researcher concerning the lack of communication between patient, physican, and nurse:

> I wish the doctors would spend more time in the unit. They spend a few minutes a day here. We are here eight hours. I often wonder if the doctor realizes how many orders for procedures he leaves for us to do? Do we invade the body too often with these procedures? I feel that in the beginning of the illness, when there are choices to be made concerning the patient's care and treatment, there might be more appropriate procedures--safer and less traumatic--more therapeutic means that might be tried if the physician were here to see the patient as we see him.

A common stressor, mentioned on tape and by those subjects who took only the qualitative portion of the research, dealt with staffing and time problems. Too little time and too few nurses on duty were two very frustrating subjects to the nurses who were interviewed. Both critical and non-critical care units seemed to have experienced this problem. The following comments seemed to point to this:

> What is very stressful is not having enough time to do the kind of nursing I would like to do. I feel that I am very thorough and very neat, and I like my patients to be comfortable and their rooms to be neat and everything done on time. Sometimes that is just not possible. I don't get it all done and that is very frustrating.

> About the only thing that stresses me is too heavy a work load, not getting to do everything I want to do for my patients. You just have to do the most important things and set your priorities.

> I know if I am busy and several patients want me at the same time, I just have to tell them to hold on and I will be there as fast as I can.
>
> We did have staffing problems. If you noticed the acuity board today, one nurse has four patients. In a critical care area, in the back of my mind, I think that is not good. That bothers me. Right now the unit is budget conscious and at our last meeting they are talking about not hiring any more people. We will have to work harder and that is alright, except, they are not thinking about the patient. Administrative people get on my case a lot. They are not patient-oriented. I am a bedside nurse.

Although the families of the patients may be of aid and support on the unit, they seemed to be one of the primary stressors for the nurses. Families created stress from several aspects. The following comments were expressed during the interviews with great meaning:

> I always try to have my patients as comfortable and looking as good as I can before the families come in. Their reactions to the loved one in this area can be stressful.
>
> Occasionally a visitor or family member will create a problem, but we resolve it quickly.
>
> Working with families can be stressful. All families react differently. If they are not taking it very well, it's hard.
>
> Families of the patients. I become so involved with some of the patients because they are here such a long time. When they first come in and may not make it, that's when we develop the closeness with the family. Sometimes, they don't want to leave the room when certain procedures must be done. It really gets bad when the patient has gotten better, and then they don't make it. I cry right along with the family. It affects the entire unit as well. I promise myself not to let this attachment happen, but each patient has something about them and you just can't help it.

The stress of death was not mentioned as often as other possible stressors but the comments appeared to have deep meaning to those who mentioned the subject. Death and dying as stressors were expressed as:

> I might add that a death on the unit would be stressful. It seldom ever happens but it would affect each of us whether it was our patient or not. I guess I'm not the hard gal I thought I was.

> It is hard for me to work with dying patients and give them the support that they need. It's difficult to give them hope, you know, something to hold on to. Often the treatment they are going through will make them sicker and you must remind them that it may prolong their life.

5. Q: What methods of stress management have you found personally helpful in dealing with your own stress on the job?

A: The methods of stress management mentioned by the nurses in the interview sessions included nine major and distinct ways in which they personally dealt with on-the-job stress. Some of these were helpful while carrying out their nursing duties, while others were helpful in dealing with job stress after they left the hospital unit.

Those methods of stress management in the order of the number of times mentioned by the nurses included: getting away from the unit; practicing some form of relaxation; communicating stresses and anxieties to others; carrying out a routine or setting priorities; engaging in hobbies; jogging; religious activities; and talking to oneself or getting more deeply involved with the patient and family. To get away from the unit either temporarily or at the end of the shift and leave it behind them seemed to be helpful to the greatest number of the nurses interviewed. The comments which indicated how helpful this management aspect was included:

> I never carry my work home. Always through the years I just leave work at work and home at home. I manage better that way. I have really learned to really not take offense at anything.

> I try to forget what's here when I leave, and I pick it up when I return. At home, that's another life. You live two lives. You live one here and one at home. The secret to managing your stress is to keep them separated.

> I just stay busy at home and don't think about work until it is time to come to work. I have been known to call on weekends to see if a patient is still here, just out of curiosity. I sometimes hope that he would not be. Suffering bothers me, but I try not to dwell on it.

> It helps to get away from the situation, just to go into another room--I go to the bathroom a lot.
>
> If I had a closet I would scream. But basically I just keep it to myself. I know that eventually I will be walking out of that unit, and I just do the best I can to get things done.
>
> Well, I don't do any of that fancy stuff like Yoga or TM. I just leave the unit at the end of the day and go home. That door shuts behind me on the elevator and I forget it. I have learned not to buy into guilt or worry because of something I had no control over. My work is not all of my life. It's just one part of it. I quickly move on and leave the patients to the staff on the next shift.

Relaxation appeared to be helpful in managing stress on the shift and upon leaving the unit. The means of relaxation were varied among the individuals. Each method of relaxation seemed to fulfill the needs of managing stress for each of the nurses as stress entered their job. Relaxation aids were reported as:

> I think that basically I have learned to deal with stress as it happens and not let it build up. I have noticed that each year I seem to relax and enjoy what I am doing more. Is that maturity?
>
> I have not had any coaching as far as it's concerned. I just find it is easier for me to gear down in a situation where I get really hyper. I just have to sit down and take a deep breath and go at it from a different angle. . . . I take a deep breath, relax and begin again. It works for me.
>
> I go home and soak in a hot tub.
>
> I listen to music, read, and when I get really wound up, I go home and clean like crazy.
>
> I have hobbies that help when I go home. But, sometimes I just go home and prepare a meal and say, 'I'm not going to do a darn thing today.' Would you believe my Christmas tree is still up? I live alone, and I just don't push myself anymore.
>
> I have learned to meditate. This is the most calming thing I have learned to do for myself. Occasionally, I share the techniques with others. It is so sensible a way to slow down the pace and learn to cope. I also take B12, E, and Lecithin. Stress is not so much a factor in my life since I found the answer for me. I don't really need another stress management technique.

Communication in the unit with peers ranked high in the methods used for managing stress. The intensive care nurses mentioned various types of communication more frequently than did the non-critical care nurses. It was explained to the researcher that the close proximity within which the critical care nurses work intensifies the need to maintain open lines of communication. This often fosters the communication because of the close working area. Stress management in the unit through communication was expressed as follows:

> I ventilate to peers some. That helps. I think we all do that.
>
> Most of the people I work with, if something is really bothering them, we just tell each other how we feel, and I think that is our coping mechanism. We help each other.
>
> We have time to talk and become a little closer than the nurses on other shifts. That helps me a great deal.
>
> When stress becomes a real problem, I can depend on the nurses in I.C.U. We can get together and talk about it, and sometimes that helps a lot.
>
> I feel that if you are aware of its (stress) presence, you can deal with it as it comes along. We are able to communicate well with each other here on the unit. We vent our gripes and frustrations and that helps.

The routine of the job was mentioned as a way of managing stress. Routines were maintained by some and were altered by others to aid in managing the level of stress. Priorities were often used to help set the routine when the situation with patients on the unit became particularly stressful. These means of coping were expressed as:

> My philosophy is to take each moment as it is. I have found out that I can only handle one thing at a time. I think I do a good job at dealing with priorities and looking at situations calmly. I don't think I have a big problem with stress.
>
> I have a set routine where I set out my medicines, and I give them when I take temperatures, and that way I am not rushed to give meds and I can spend a little more time. If a lot of people start calling from their rooms, I just ask them to be patient and I will be along, that I can just do one thing at a time. I will get there sooner or later.

> When I become stressed on the job, I just automatically set my priorities and do what has to be done first. Then I do the things that aren't as important to patient care when I have the time.
>
> I just go about my business. I take care of my patients and help the other nurses if they need help and they ask me.
>
> I just go about my business and do the best I can because there is usually nothing you can do to change the situation. One nice thing to look forward to is your turn on the remote monitor. If you have had a real stressful two or three days on the floor, you look forward to being on remotes the next time you come in. Remote monitors have their own stress factors, but I look forward to that break in the routine.

During the interviews and in times of observation in the nursing stations and lounges, a number of hobbies were mentioned as ways of combating job stress upon returning home. Jogging, cooking, baking, sewing, knitting and needlework, religious activities, pets, and spending time with family and friends were all mentioned as typical ways of coping with any residual stress from the job.

In summary, this researcher taped one interviewee who expressed an attitude which represented the nursing personnel in their involvement as a whole. Although a few of these discussions were taped, many were observed by the researcher over the weeks while spending time around the clock within the units. The following comment expressed many of the various statements made by nurses to each other, directly to the researcher in person, and in telephone conversations during traumatic periods. Regarding serious illness or death as a stressor, one nurse who was interviewed stated:

> When I first came in here I tried to ignore it. If I didn't talk to the family, then I didn't have to deal with the problems. I realized right away that was not going to work, that the problems do exist. It helps me and it relaxes the family a lot to jump right in there and cry with them. I just stay with them. You don't always have to have the right words. It seems to help them to know you are right there. It helps me as well.

In studying frequency of stress, or how often a situation was perceived by the nurse to be personally stressful, nine independent variables were utilized. Of the nine hypotheses drawn from the variables, only two were rejected at the .05 level, or lower, showing a significant relationship between the selected independent variable and frequency of stress (see Table III).

In rejecting the null hypothesis regarding race and frequency of stress, the minority nurses were found to experience significantly greater frequency of stress than did white nurses. Eight minority nurses were represented in the study. This accounted for 11 percent of the study. Seven of the eight nurses were in the 20-29 age category. The age factor and intensity of stress indicated that the younger the nurse, the more deeply stress was experienced. Although the age factor and frequency of stress was not found to be significant, the mean score for the 20-29 age group was higher than for the other two age groups.

With fewer years in nursing for seven of the subjects and with the added societal pressure to succeed in a traditionally white occupation, dominated by females, the minority nurses (all women) may have a strong tendency to perceive situations to be stressful more often than did their white colleagues.

Of the 18 subjects interviewed, two were minority nurses. One minority nurse, who had been licensed only six months, made a statement which may hold meaning in this context. When asked "What factors of your job create the most stress for you?" she made the following statement:

> Personalities. Jealousies on the unit really get to me. It seems to interfere with my ability to relax at times, and put first things first. We have to be aware of each move and each word so as not to upset a few people on the unit. I have not become as at ease with setting my priorities as I had hoped to be by this time.

In rejecting the null hypothesis for marital status and frequency of stress, it was determined that there was a significant relationship between the divorced category having the greatest frequency of stress and the married category having the least evidence of frequency of stress. No significance was determined between the other two categories of single and widowed.

Twelve of the subjects were divorced. This number represented 16 percent of the nurses. Of the 12 divorced nurses, 5 were white and 7 were in the minority category. These 7 nurses were also in the 20-29 age group. Although age was not found to be significant when compared to frequency of stress, it is possible that the 20-29 category, having the highest mean of the three groups, may have been a contributing factor.

Frequency of stress in the critical and in the non-critical units was not found to be significant. However, 8 of the 12 divorced nurses were in the critical care specialties. Storlie indicated that the added factor of the critical care "setting is in itself a major stress for the nurse."[1] Five of the minority nurses who were divorced had one to two children.

This information strongly indicated a summing effect of the variables to create significance between frequency of stress and both race and the divorced marital status.

The married category, having the lowest frequency of stress, represented 50 percent or 36 of the subjects in the study. One nurse was in the minority category, and the remaining 35 were white. The married nurses were divided between critical and non-critical care with 19 in critical and 17 in non-critical care units. This information indicated

a slight difference in findings with Maloney, who stated that one of the behavioral effects of nursing stress was marital conflicts.[2] This factor tended to be more accurate with regard to the minority category than in the white category in this study. Once again, this may lead to a conclusion that minority nurses may have an added societal pressure to deal with which is less present in white nurses.

No significant difference was found to exist between frequency of stress and the remaining seven independent variables. Age has been discussed in both race and marital status as a possible contributing factor. These non-significant areas hold some possible information as to the reason for acceptance of the null hypotheses.

The highest degree held by any subject was a Bachelor of Science in Nursing (BSN). Four nurses were working toward an advanced degree, but none had been completed at the time of the research. No significance was determined in this category. There are similarities which exist among the nursing personnel regarding the highest level of education completed, as well as some differences. The differences lie in the number of years each category represents in education for licensure in nursing. The Licensed Practical Nurse (LPN) is a one-year academic program providing for education in the fundamentals of patient care. An LPN is not permitted to provide full patient care due to the lack of courses dealing with medicines and the more intensive nursing procedures.

The Associate of Science in Nursing (ASN) graduate has completed a two-year program which closely parallels the three-year education of the hospital diploma nurse and the actual course work in nursing (the last two years of a four-year program) of the Bachelor of Science in Nursing

(BSN) graduate. The ASN does not include the range of general education courses and electives that accompany the four-year BSN degree.

Although the differences lie in the partial or full range of duties which were performed and in the number of years of education each was required to take to become a nurse in each category, there were several important similarities.

Each of the nursing personnel was licensed to practice nursing in the state of Oklahoma, following licensing tests which are given for each category of nursing. Upon passing their specific licensing examination, each of the nurses worked together in a unit under the same conditions while doing many of the same type of duties. They shared the same joys and frustrations. While working in the unit, the similarities seemed to take on a more important perspective, and the differences in length of education became less a factor in the levels of frequency of stress as perceived by each nursing personnel. The means in this area were so close that the range difference between high and low was less than 2.30.

The number of years in nursing did not indicate a significant difference when compared with frequency of stress. Nursing is a profession which encourages the entrance of individuals into its ranks at any age. Therefore, years of nursing experience and age categories may not match perfectly. It may not follow that all nurses who have been practicing for under five years are in the 20-29 age category. This could easily be a 30-39-year-old or a 40-49-year-old nurse who has just entered the profession. The actual range of years in nursing experience in the study went from six months to 44 years. Forty-five percent of the nurses were in their first five years of nursing, regardless of their age. The mean range was from 79.697 to 80.8421 with a difference of less than

1.15. Years of experience as a nurse seemed to be of little importance in the nurses' perceptions of the frequency of stress experienced.

In comparing the size of the unit of specialization with the frequency of stress, the results indicated that there was a mean range difference of less than 2.30 between the highest and lowest categories. At the time of this study, the nursing shortage in greater Oklahoma City was over and hospitals were able to fill available positions. This situation followed a time in 1980 and 1981, when there had been a great shortage of nurses in Oklahoma City area hospitals. Competition was keen between hospitals for nursing personnel. At that time, this researcher feels that the shortage of nurses might have had a different effect on this item, since the units were often covered with fewer personnel than at the time of this study.

A down-turn in the economy in late 1982 and early 1983 brought nurses back into the field and promoted this fully staffed situation. With fully staffed units in each of the three hospitals utilized for the study, conditions were fairly equal in each of the categories of unit size. Nurses still complained of having too little time and too much to do to maintain excellent patient care, but there appears to be no imbalance of frequency of stress experienced due to the size of the unit. Units were, usually, adequately staffed for the number of patients on the unit and the nature of the nursing care.

Critical and non-critical care units showed no significant difference in frequency of stress. The mean range of less than 1.00 indicated that the perceptions of frequency of stress were very close for the subjects in this study regarding critical and non-critical care specialties.

As a result of the qualitative research obtained through the interviews, this researcher found that 17 of the 18 nurses were pleased with their specialty unit. It is the belief of this researcher that stress was less evident when nursing personnel were working on the unit of their choice. The critical care areas were reputed to be the more stressful of the two by the nature of the patient care and the critical care atmosphere. A nurse would not choose a critical care area unless there was interest and motivation to work in the highly charged atmosphere of that specialty unit. Stress can often be perceived to be all distress or negative in nature. It is possible that the motivation and interest, coupled with a feeling of really being able to make a difference in the patient's recovery, may be perceived by nursing personnel in critical care areas as eustress or a positive attitude. This may not be perceived as abnormally stressful since the stress was expected to be experienced in the critical care unit.

The subjects in the study were evenly divided between each of the three hospital shifts. The frequency of stress was lowest in the 7 a.m. to 3 p.m. category with a mean of 78.4167. The 11 p.m. to 7 a.m. shift appeared to be stressed most frequently with a mean of 85.2174. The mean range difference was under 7.0. This was not significant at the .05 level, but this variable had the third lowest probability with 0.1077.

The researcher noticed an unusual situation in the means of these categories. The 7 a.m. to 3 p.m. nurses perceived their frequency of stress level to be the lowest. This shift has traditionally been viewed as the busiest shift with new patients being admitted, others being discharged, plus many medical, laboratory, and nursing procedures taking place, and yet, the nurses on this shift perceived their frequency of

stress level to be the lowest of the three shifts. Conversely, the 11 p.m. to 7 a.m. shift has been thought to be the least busy shift due to the normal sleeping hours of most of the patients. However, these nurses perceived stress to occur more frequently than did the nurses on the other shifts. Although 15 of the 18 nurses who were interviewed were working the shift of their choice, the same cannot be assumed for the remaining nurses on the shift who were not interviewed. The possibility arises that there may have been nurses who were working the 11 p.m. to 7 a.m. shift who found the shift stressful and perceived the activities of the shift as stressful more often than did the nurses on other shifts.

Comparing the number of in-service courses completed to the frequency of stress indicated no significance between the categories. The 14-item demographic questionnaire requested that the nurses write in the titles of any in-service courses that had been helpful in managing stress on the job. Only 44 percent, 32 of the 72 respondents, listed any type of in-service course which was helpful in managing on-the-job stress. The remaining 40 nurses indicated that they had not attended an in-service course of any type which had aided in stress management. It appeared to this researcher that the number of in-service courses was not the relevant factor. The quantity of courses was not meaningful in the frequency of stress. The lowest mean was in the category of 50-and-over in-service courses. The mean for the category of 10-and-under in-service courses was the highest. The researcher feels that the frequency of stress was not affected by the number of courses completed, but by the quality of the courses as they related to stress management. The more

courses a nurse attended, the more likely one or more of those courses would have been related to stress management in some way.

In adding the five-point intensity of stress scale to the existing frequency of stress scale on the 34-item Nursing Stress Scale, this researcher was able to gain a great deal of additional insight into the occupational stress of the acute care hospital nurse.

Of the nine hypotheses compared to intensity of stress, the null hypothesis of age and intensity of stress was the only one rejected at the .05 level of significance. The remaining eight null hypotheses were accepted (see Table I).

Significance was not found between frequency of stress and age, but the nurses indicated on the Nursing Stress Scale that there was a significant difference between the 20-29 age category with the highest intensity level, and the 40-and-over category with the lowest level of intensity of stress. There was a significant difference between the 20-29 and the 30-39 age category as well. No significant difference was ascertained between the 30-39 and 40-and-above groups. This difference in the statistical results of frequency and intensity of stress indicated that, although nursesin each age category experienced little difference in the number of stressful events that occurred, the 20-29 age group experienced those events with much more intensity than did the 30-39 and the 40-and-over categories. These results tended to indicate that years of experience as a nurse were important in the development of techniques to manage the levels of intensity of stress. The experiences gained through years of living as a factor in stress management was indicated here as well (see Table II).

This researcher feels that experience was the key to the management of levels of intensity of stress. What was difficult to ascertain was whether that experience was job related, based upon years of living or a combination of both. If experience is the key, then a possible solution to stress management experience is through well selected in-service education programs which deal with stressful areas of the nursing personnel, the patient, and the unit of specialization.

Several of the seasoned nurses who were interviewed had 25 years or more in nursing experience. They related that they could now relax and enjoy nursing duties and their patients. They were ready to let the younger nurses go for the challenge of the critical care specialties and let them have the opportunity to test themselves. The older nurses mentioned that they had earned the privilege to do their job without looking for mountains to climb. This relaxed, and less rushed, and hassled attitude was evident to this researcher as opposed to the hurried, and often anxious attitudes of the younger nurses. Perhaps, the luxury of having proven oneself does have a way of helping to manage the tension and the intensity of stress.

Race and frequency of stress was determined to be significant, but there was no significant difference due to intensity of stress with regard to race. These findings tend to indicate that, although the minority nurses experienced stress more frequently, all of the nurses experienced the level of stress with approximately the same degree of intensity.

This researcher noticed that the nurses often filled the role of a safety valve for each other on the unit. They seemed to anticipate a growing level of stress in one another, and intervened to help keep the

situation under control. This reaction to impending stress and anxiety contributed to the resolution of many potential problems on the unit. The level of intensity of stress may be checked with communication and, in part, controlled with this intervention technique.

Intensity of stress and highest degree earned proved not to be significant in this study. It appeared to be of little consequence to the nurses in each of the units as to what letters appeared after the name on each name tag. LPN or RN designated the type of duties each could perform, which to a great extent are the same. The nurses seemed to treat one another as professionals. Licensed Practical Nurses were in positions of management within various units of the hospital. This variable showed little indication of having importance in terms of levels of stress.

Marital status and intensity of stress indicated a mean difference of more than 9.0 between the divorced group as the highest and the married group with the lowest intensity of stress. No significance was determined. As was mentioned previously regarding race, the atmosphere on the unit may contribute to the resolution of the problem in many cases before the intensity of stress becomes excessive.

The years spent in nursing provided no significant difference in the levels of intensity. The difference between the high and low mean as 0.1688. This figure is not statistically significant; however, there is some discernible difference in this sample of the perception of intensity of stress. The over 10 years of experience group represented the low mean, and the group with 5 or less years of experience represented the high mean. This researcher chose to use the 0-5, 6-10, and over-10 categories for this study. The categories could have been enlarged to

encompass more years with the upper group considered to be the over-20 group in years of experience. It was difficult to determine the composites of the nurses before the research was conducted. There was concern that the over-20 category would not provide enough subjects to be used in the statistical process of analysis of variance. If it had not been for this concern, the researcher would have used the larger categories. In retrospect, the decision was a wise one due to the fact that only four nurses in the study fit in that category. That would have encouraged a large margin of error. It is the feeling of the writer that significance could be found in the variable with a larger sample and the expanded categories in a further study.

The literature on nursing stress indicated that the stress levels experienced by intensive care nurses was much greater than non-critical areas of nursing. This study found no significant difference in intensity of stress and the critical and non-critical care hospital nurses. The mean difference between the two groups was less than 2.20. There are several possible factors which may point to the reason for this result. In the three hospitals utilized for the study, the critical care areas had a mechanism in place within the units to deal with stress. These took the form of support groups and group counseling held informally among the nurses, and formally when all nurses on the shift could attend. Communication was mentioned repeatedly in the interviews as a method of stress management, which was helpful. This stress mechanism was not in place for the non-critical care units at the time of the study.

Another contributing factor was brought to the attention of the researcher concerning the staffing practices at the three hospitals. The hospitals included the Oncology unit (the terminal cancer patient) as a

non-critical specialty due to the similarity in staffing with non-critical care units. The designation of the hospitals was used in this study to differentiate between critical and non-critical care categories. The Oncology nurses appeared, by far, to be the most outwardly stressed of all of the 72 subjects. This writer made extensive notes concerning the reactions of the Oncology nurses when they were made aware of this fact during the testing. They were each shocked and even angered to find that they were considered to be in non-critical areas. Their comments included the fact that they faced death every day, and that was certainly not non-critical. A head nurse in a critical care area stated to the researcher that if she were doing the staffing for Oncology that she would staff it more like the Intensive Care Unit. The placement of the Oncology nurses in the non-critical category may have greatly contributed to the outcome of the statistics in the hospital unit variable.

The size of the unit and level of intensity of stress proved to be of less significance in this study due to the fully staffed units at the three hospitals used in the study. Intensity of stress may be less of a problem in a unit if it is properly staffed with nurses. Each unit was appropriately staffed during this research. This indicated that there was a low level of perceived stress in the size of the unit regarding intensity when all ofthe nursing personnel were equally overworked.

The work shift indicated no significant difference regarding levels of intensity of stress. As was the case with frequency of stress, most of the personnel were able to choose the shift of their choice. This fact seemed to eliminate the probability of excessive levels of intensity of stress being perceived on any shift.

The number of in-service courses appeared to have little impact on the levels of intensity of stress in the hospital nurse. The number of courses a nurse had taken did not greatly affect the intensity of stress in this study. A great need was found to exist in each of the hospitals for a comprehensive stress management course for each nurse.

In considering occupational stress and the acute care hospital nurse, several speculations can be made. First, the perceived levels of frequency and intensity of stress are not the same. There may exist a difference in the number of times you experience stress and in the strength of that stress experience.

Second, due to a number of possible personal factors, race and frequency of stress indicated a close relationship. The previously white dominated field of nursing may still hold some additional stress problems for minority nurses.

Third, age and levels of intensity of stress appeared to have an interaction. The older nurses expressed less perception of stress, indicating the importance of either nursing experience or years of living or both in the management of stress. The younger the nurse the more elevated the intensity of stress became.

Fourth, the divorced nurse had the greatest incidence of stress in both frequency and intensity than any other category of marital status. The married nurse appeared to be less affected by stress on the unit in both frequency and intensity.

Fifth, the hospital administrators do not look at staffing of units with levels of stress of the nurse in mind or strictly with critical or non-critical care as their perspective. The nursing personnel look at

staffing from a personal and a patient viewpoint. This factor may be a stressor to nurses in itself.

In summary, this researcher taped on interviewee who expressed an attitude which represented nursing personnel in their involvement as a whole. Although few of these discussions were taped, many were observed by the researcher over the weeks while spending time around the clock within the units. The following comment expressed many of the various statements made by nurses to each other, directly to the researcher in person and in telephone conversations during traumatic periods. Regarding serious illness or death as a stressor, one nurse who was interviewed stated:

> When I first came in here I tried to ignore it. If I didn't talk to the family, then I didn't have to deal with the problems. I realized right away that was not going to work, that the problems do exist. It helps me and it relaxes the family a lot to jump right in there and cry with them. I just stay with them. You don't always have to have the right words. It seems to help them to know you are right there. It helps me as well.

One of the most difficult tasks of a researcher is to try to understand what the data are reflecting. It is believed that these interpretations may contribute to a more precise understanding of the study. The researcher believes that there is presented in this research a factual and realistic representation of the findings. Further, the researcher believes that she has accomplished what the basic concept and design of the study was to produce.

NOTES

[1]Frances J. Storlie, "Burnout: The Elaboration of a Concept," American Journal of Nursing (1979), p. 2109.

[2]Joseph P. Maloney, "Job Stress and Its Consequences on a Group of Intensive Care and Monintensive Care Nurses," Advances in Nursing Science (1982), p. 31.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Introduction

The previous chapters of this study have outlined the concept of the study, a review of the literature, the methodology by which the study was conducted, and the quantitative and qualitative findings. This final chapter will be directed to a general summary of the findings of the research and recommendations for future study.

Summary of Conclusions

This study has been an attempt to explore selected aspects of occupational stress in the acute care hospital nurse. The study was specifically confined to three acute care hospitals in the greater Oklahoma City, Oklahoma, area.

The nine independent variables were subjected to one-way analysis of variance in comparison to both frequency and intensity of stress as measured on the Nursing Stress Scale, creating 18 hypotheses. After applying analysis of variance to the null hypotheses, it was found that two of the null hypotheses were rejected at the .05 level, or lower, in relationship to frequency of stress. Significance was found relative to race and frequency of stress, and marital status and frequency of stress.

Minority nurses experienced significantly higher levels of frequency of stress than did white nurses. Divorced nurses were found to experience

significantly higher levels of stress more frequently than did married nurses. No significant difference was found between the remaining categories of single or widowed nurses.

The remaining null hypotheses, as compared to frequency of stress, were accepted. Those hypotheses included: age, degree, years in nursing, hospital unit, work shift, number of in-service courses, and size of unit of care.

Regarding intensity of stress, one of the null hypotheses was rejected at the .05 level, or lower. Age and intensity of stress was determined to be significant. It was determined that a significant difference existed between the 20-29 age group and the over-40 age category. Significance was also found between the 20-29 and the 30-39 age category. No significance was found between the 30-39 and 40-and-over groups.

Five structured questions were utilized in interviewing nurses while on the job in their unit of specialization. The interview data indicated that the majority of nurses were working the shift and the specialty unit of their choice. The majority of nurses indicated that the nature of patient illness or the possibility of serious complications was a very important factor in their choice of hospital unit in which to work. The job satisfaction factor was very evident in many of the interviews.

A variety of factors were mentioned which created stress for the nurses on the job. Those factors included: personalities, lack of communication, too little time or staff, families of patients, and death.

The methods of stress management mentioned by the nurses in the interview sessions included a number of major and distinct ways in which they personally dealt with stress. Some of these were helpful while carrying out their nursing duties, while others were helpful in dealing

with job stress after leaving the hospital unit. The methods mentioned by the nurses included: getting away from the unit, practicing some form of relaxation, communicating stresses and anxieties to others, carrying out a routine or setting priorities, engaging in hobbies, jogging, religious activities, or becoming more involved with the patients and their families.

Recommendations for Future Research

The quantitative and qualitative findings in this study can be used as a basis for generating future investigation in several areas:

1. More research needs to be done regarding the impact of frequency and intensity of stress in the nurse. This needs to be accomplished in order to understand more fully the interaction between these two components of stress and their impact in the occupational setting of the nurse.

2. Further investigation needs to be conducted on the difference in the levels of intensity and frequency of stress between critical and non-critical care nurses with a larger sample. This researchers suggests that Oncology and Hospice nurses be considered as critical care providers in any further study.

3. Research also needs to be conducted on age and levels of stress. By utilizing a sample large enough to allow age group categories of 20-29, 30-39, 40-49, and 50 and over, the interaction between age and perceived levels of stress can be more fully understood.

4. Research is needed to incorporate the effects of a comprehensive in-service stress course on hospital nurses' levels of frequency and intensity of stress. This could be accomplished by using the Nursing Stress Scale in a pre-test, post-test research method.

Summary Statement

The major purpose of this study was to investigate the frequency and intensity of stress in selected specialty areas of critical and non-critical care in the acute care hospital nurse. What is hoped by the researcher is that the present study has not only contributed to the growing body of research on nursing stress, but that additional questions and problems have been raised that will generate more in-depth study and research concerning frequency and intensity of stress in hospital nursing personnel.

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APPENDIX A

INTERVIEW QUESTIONS

Interview Questions

1. Are you working in the unit of your choice?

   Why did you choose the _____ unit?

   (Or) What unit would you prefer?

   Why?

2. Are the scheduled hours of your shift the working hours you prefer?

   Why? If not, why not?

   What hours would you prefer?

3. Was the nature of patient illnesses or the possibility of serious complications or death a major factor in your choice of hospital units?

   How important was this factor?

4. What aspects of your job do you feel create the most stress for you?

5. What methods of stress management have you found personally helpful in dealing with your own stress on the job?

APPENDIX B

INTERVIEWS CONDUCTED WITH HOSPITAL NURSES

INTERVIEW 1

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

The I.C.U. unit.

IS THIS THE UNIT OF YOUR CHOICE?

Yes, I prefer the ICU but I would also like to work in Coronary Intensive Care because I feel that my time on the job is well spent on these units.

2. WHAT HOURS ARE YOU WORKING?

11-7 shift.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes.

WHY DO YOU PREFER THIS SHIFT?

I have worked the 3-11 shift and still do occasionally. However, I prefer the sanity of the 11-7 shift. This shift also fits into my life style better than the others.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Basically yes, because they give you more of a feeling of gratification in taking care of the patient if you are successful. We have a lot of long-term patients, a lot of sick people and it gives you a certain amount of satisfaction in taking care of them. We often get very attached to them. They become friends.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

Very important because I need a sense of being needed.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

Basically, a lack of communication, I think, sometimes between nurses and doctors and actually what we are doing for the patients. I think that is the biggest problem. There is a big breakdown in things transferred through nurses that could affect the patient's care, actually affect what you did for the patient and what you did not. That is often not communicated and creates great stress for me.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I have not had any coaching as far as it's concerned. I just find that it is easier for me to gear down in a situation where I get really hyper. I just have to sit down and take a deep breath and go at it from a different angle. A lot of times the added stress has a big effect on actually what you do and how

INTERVIEW 1 (Continued)

you do it. I find that it is sometimes helpful for me to walk out and come back in. I take a deep breath, relax and begin again. It works for me.

INTERVIEW 2

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am working in I.C.U. right now.

IS THIS THE UNIT OF YOUR CHOICE?

Yes, my first choice is Intensive Care; however, I think I would enjoy the Emergency Room due to the variety of patients that they see in their duties.

2. WHAT HOURS ARE YOU WORKING?

7-3 shift at this time.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

I miss sleeping late but I enjoy this shift best. I have worked each of the three and I prefer the early shift.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Yes, I think that the more critical the patient, the more challenging my job is to me. I like the challenge. I also like the response I get from my patients and from myself. It is gratifying when something happens and I am able to help save them. Sometimes we keep our patients for a long period of time and I become attached. It is always heartwarming to see a patient move out of critical care and be sent to another unit on the way to recovery.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

This was a very important factor to me. I don't enjoy the death part but I like all the other aspects of my job.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

In my position as Assistant Charge Nurse on the day shift I experience a great deal of stress. We have emergency situations when there is not a doctor available and we don't have any order to go ahead and do something; that is the biggest stress. Certain doctors create a stressful situation because they do not like for you to suggest things and they seem to get defensive about it. This may be because you have hit on something that they were not aware of.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

When stress becomes a real problem, I can depend on the nurses in I.C.U. We can get together and talk about it and sometimes that helps a lot. It helps to get away from the situation, just to go into another room--I go to the bathroom a lot. At

INTERVIEW 2 (Continued)

home I try not to think about it or talk about it to my boy friend. I listen to music, read, and when I get really wound up I go home and clean like crazy.

INTERVIEW 3

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am in Med/Surg, a non-critical care unit.

IS THIS THE UNIT OF YOUR CHOICE?

Yes, for the present time. I would like to get into one of the specializations after I get a little more seasoned. I have not been a nurse but six months and I'm not personally ready for a critical unit yet.

2. WHAT HOURS ARE YOU WORKING?

11-7, the night shift.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

No, but when you are new you have to take the openings where you can find them. I am single and this shift does not contribute to my life style at the present time.

WHAT SHIFT WOULD YOU PREFER?

I would rather work the 7-3 shift since that coincides with the rest of my friends and their working hours better than any other. I don't enjoy sleeping my days away.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Yes, definitely. I am not ready for serious emergencies at the present. I really respect those who work with the critical patients and hope to do so in the future. I like the care I am able to give now. I feel good about my job.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

Very important. Out of personal necessity I was pleased with my assignment.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

Personalities. Jealousies on the unit really get to me. It seems to interfere with my ability to relax at times and put first things first. We have to be aware of each move and each word so as not to upset a few people on the unit. I have not become as at ease with setting my priorities as I had hoped to be by this time.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I am very religious and I find help in my Bible study and prayer. I also talk with a friend when the going gets too rough. I think I am dealing with stress fairly well now. I feel that

INTERVIEW 3 (Continued)

becoming more familiar with my job is helping. I keep active in my spare time doing things I enjoy and that helps. I jog, cook, read, and enjoy my friends.

INTERVIEW 4

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am working in a medical-surgical unit at the present time.

IS THIS THE UNIT OF YOUR CHOICE?

Yes, I like working in a specialized area and yet I enjoy the variety. I feel that I am in the mainstream of the hospital in a med-surg unit.

2. WHAT HOURS ARE YOU WORKING?

7-3 shift.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes, although I do not like the weekend work. I am off on weekdays and I work the weekend.

WHY DO YOU PREFER THIS SHIFT?

The hours are the most normal that nurses have to choose from which correspond with the rest of the world. I don't like being isolated from the rest of the world.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Not really. I don't mind dealing with the complications. I find more difficulty in dealing with the family members.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

This factor was not very important to me at all.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

I think it would have to be the difficulty in communicating with the physicians. Another would be the stress of dealing with families and their criticism of nursing care. We are giving the best we are able to under present conditions. This attitude of some families really gets to me.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

My philosophy is to take each moment as it is. I have found out that I can only handle one thing at a time. I think I do a good job at dealing with priorities and looking at situations calmly. I don't think I have a big problem with stress.

INTERVIEW 5

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am in the I.C.U. unit.

IS THIS THE UNIT OF YOUR CHOICE?

Yes. I came to the critical care from the Hemodyalisis Unit and really enjoyed that. I enjoy the critical care unit where I am now very much.

2. WHAT HOURS ARE YOU WORKING?

I am working from 7:00 a.m. to 7:00 p.m.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes. I enjoy the time here and I especially enjoy the time off. Working 12 hours on makes the work week go by in a hurry. When I go home I just take a shower and really one of the main things I do is just not to do anything. I just go home and sit. Sometimes I just can't stand to pick up the paper. I just don't want to do a thing.

WHY DO YOU PREFER THIS SHIFT?

One of the things that I think is so wonderful about my shift is that every two weeks I have five days off and I am able to get just completely away. I really need it and it helps.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Not the death. My main reason for choosing I.C.U. is that I like fast paced nursing. I like challenges all the time and I guess those occur from the serious illnesses. It is not routine.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

The possibility of complications and the need to work with those types of situations makes this a very important unit for me.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

What is very stressful is not having enough time to do the kind of nursing I would like to do. I feel that I am very thorough and very neat and I like my patients to be comfortable and their rooms to be neat and everything to be done on time. Sometimes that is just not possible. I don't get it all done and that is very frustrating.

Inadequate staff as far as numbers is very stressful. Communication problems with doctors is often stressful. I have very little communication problems with other staff members. Mechanical breakdowns of machinery and not feeling that I am adequately

INTERVIEW 5 (Continued)

prepared to maybe run and manage some of the machinery and being thrown into some situations I don't feel that I am prepared for and yet other people feel that I am ready for can really get to me. But I have to do it anyway.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I probably have the worst kind. I just usually keep it to myself and just keep going. I realize that it's just not going to do any good at that moment to complain. It's great stress but I just keep on going. If I had a closet I would scream. But basically I just keep it to myself. I know that eventually I will be walking out of that unit and I just do the best I can to get things done.

I jog three miles a day in the morning at 5:00 a.m. before I go to work so I can't say if that relieves my stress from the day before or not. I just do this for me.

INTERVIEW 6

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am working in a medical/surgical unit.

IS THIS THE UNIT OF YOUR CHOICE?

Yes, this is the easiest duty I have had in my years as a nurse. At this time it is perfect for my needs.

2. WHAT HOURS ARE YOU WORKING?

At this time I am working 3 to 11.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes, because I am not a morning person. I don't function well until after noon and this shift is the best for me.

WHY DO YOU PREFER THIS SHIFT?

I can run my errands on the way to work when the stores and shops are not so crowded. After work I always just want to go home and put my feet up.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Yes. I don't really want to deal with any really serious complications right now. At one time the challenge was what I wanted. I felt the need to prove myself and appear competent to others. Now, I know what I can do and I am satisfied to do that well and let the younger nurses find their own stride. I like the recovering patient. I could do without some of the complaints I hear from those who want to go home sooner than they should, but I always figure when they get to that point that they are well on the way to recovery.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

It was very important at the point in my career.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

You are going to think that I am unfeeling and hard, but very few things create much stress in my job anymore. I like it that way. I can go about my tasks and nursing duties for my patients without the butterflies of stress and uncertainty. It took a while to get to that point, but 'boy' is it pleasant when it happens. I would not go back for anything. I might add that a death on the unit would be stressful. It seldom ever happens but it would affect each of us whether it was our patient or not. I guess I'm not the hard gal I thought I was.

INTERVIEW 6 (Continued)

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

Well, I don't do any of that fancy stuff like Yoga or TM. I just leave the unit at the end of the day and go home. That door shuts behind me on the elevator and I forget it. I have learned not to buy into guilt or worry because of something I had no control of. My work is not all of my life. It's just one part of it. I quickly move on and leave the patients to the staff on the next shift.

INTERVIEW 7

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

The Intensive Care Unit.

IS THIS THE UNIT OF YOUR CHOICE?

I have worked Ortho and Neuro for about six or seven years and I quit feeling like a nurse out there. I was a real good waitress and I could give a lot of pills and a lot of meds but down to earth nursing you just don't get out there. So I came in here very frightened. I had never worked Intensive Care before. In here there is a daily challenge. I definitely prefer I.C.U.

2. WHAT HOURS ARE YOU WORKING?

I work 3-11.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

This shift is fine for me right now. I work others to fill in but I like this one.

WHY DO YOU PREFER THIS SHIFT?

This shift seems less hectic than 7-3. Yet, the challenge is there. I don't function well on the night shift.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Yes. I'm not saying the nurses on the floor don't have a needy job to do because they have and it's impossible to do without them, but after a while it gets so humdrum. I loved the people but I somehow felt that I had lost my nursing. I do not feel that way behind these doors.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

Families of the patients. I become so involved with some of the patients because they are here such a long time. When they first come in and may not make it, that's when we develop the closeness with the family. Sometimes they don't want to leave the room when certain procedures must be done. It really gets bad when the patient has gotten better and then they don't make it. I cry right along with the family. It affects the entire unit as well. I promise myself not to let this attachment happen but each patient has something special about them and you just can't help it.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

When I first came in here I tried to ignore it. If I didn't talk to the family, then I didn't have to deal with the problems. I realized right away that was not going to work, that

INTERVIEW 7 (Continued)

the problems do exist. It helps me and it relaxes the family a lot just to jump right in there and cry with them. I just stay with them. You don't always have to have the right words. It seems to help them to know you are right there. It helps me as well.

INTERVIEW 8

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

My unit is a general medical/surgical unit.

IS THIS THE UNIT OF YOUR CHOICE?

Yes, I have been on this unit since I became a nurse. I prefer this unit and I like the patients very much. Pediatrics would be my second choice.

2. WHAT HOURS ARE YOU WORKING?

I work the 3:00 p.m. to 11:00 p.m. shift.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes, I enjoy this shift.

WHY DO YOU PREFER THIS SHIFT?

Well, even with weekend duty this shift would be my choice. This shift allows me some day time for myself.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

I had worked with this type of patient when I was a nurse aide and I was very familiar with the duties and felt comfortable, so I chose to stay in this area.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

This was important to me at the time I got out of school. I wasn't ready to deal with a lot of problems and the difficulty of learning a totally new specialty area. I like the familiar.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

Occasionally we get a lot of critically ill patients and I can't spend the extra time with them that I would like. I can't do the extra things for them, like talk to them and turn them as often as I would like. It is hard for me to work with dying patients and give the support that they need. It's difficult to give them hope, you know, something to hold on to. Often the treatment they are going through will make them sicker and you must remind them that it may prolong their life.

I know if I am busy and several patients want me at the same time, I just have to tell them to hold on and I will be there as fast as I can.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I have my own set routine where I set out my medicines and I give them when I take temperatures and that way I am not rushed

INTERVIEW 8 (Continued)

to give meds and I can spend a little more time. If a lot of people start calling from their rooms, I just ask them to be patient and I will be along, that I can just do one thing at a time. I will get there sooner or later.

I have found that Bible study and prayer have helped, but my routine is most helpful in dealing with stress on my shift. I don't think about the hospital when I walk out the door. When I get home I have two dogs waiting and they help me forget. If something is really bothering me, I go to my supervisor and she will help me out. One of the Nursing Education people tried to get a support group started on our shifts as they have on 7-3. There was just no good time to get everyone together. I would like to have a group started, but I don't think we will here.

INTERVIEW 9

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

My unit is I.C.U.

IS THIS THE UNIT OF YOUR CHOICE?

Yes, but I also enjoy working on a medical floor.

2. WHAT HOURS ARE YOU WORKING?

The night shift, 11-7.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

No! I would definitely prefer the 7-3 shift.

WHY DO YOU PREFER ANOTHER SHIFT?

I do not like working nights. I will work days just as soon as I can work into a spot on the unit and I hope it is soon.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

No, not really. I had worked two years on a medical floor and I began to be a pill pusher and as a team leader I ordered other people around and I missed the actual patient care, so that's why I changed. We really do it all here.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

There are always personalities and you have to work around those. You can't try to make everybody like you or like to work with you. You just have to endure it. Working with families can be stressful. All families react differently. If they are not taking it very well, then you can't help them very well. It's hard. On this shift we have less contact with families and even with the physicians. Sometimes we have to call them at home and that can be stressful. The girls on the day shift complain about some of the doctors. They do a lot of squawking about what the doctor said and what he insinuated. We are spared that on this shift.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I go home and soak in a hot tub. Most of the people I work with, if something is really bothering them, we just tell each other how we feel and I think that is our coping mechanism; we help each other. I have thought about jogging but my energy level is so low that soaking in the tub is the best thing.

INTERVIEW 10

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am working on a medical floor.

IS THIS THE UNIT OF YOUR CHOICE?

Yes. I have time to get all my charting done. If my patients are resting comfortably, this can be a very sane place to be. We are a closed floor which keeps us from being transferred to another unit without notice, if they are short of nurses. I appreciate that very much.

2. WHAT HOURS ARE YOU WORKING?

I work from 11:00 p.m. to 7:00 a.m.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes. Believe it or not. Sometimes I wonder why I want to work at night. I guess it just suits me.

WHY DO YOU PREFER THIS SHIFT?

The quiet, and sanity, the lack of visitors, the ability to get my work done and leave on time--all of these reasons, I guess.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

I feel comfortable with these patients and I have no reason to change at this time. I guess I like what I'm doing.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

It had some bearing but I could work in another area and do just as well.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

A persistent buzzing from a restless patient can get to me. They don't realize that I have standing orders to follow and cannot give meds at will. Other than that, there are few things that create more than normal stress on this shift. I guess that's why I like it.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

We have time to talk and become a little closer than the nurses on other shifts. That helps me a great deal. I think that basically I have learned to deal with stress as it happens and not let it build up. I have noticed that each year I seem to relax and enjoy what I am doing more. Is that maturity?

INTERVIEW 11

1. IN WHICH UNIT ARE YOU PRESENT WORKING?

I am in I.C.U.

IS THIS THE UNIT OF YOUR CHOICE?

Yes. I don't think one works I.C.U. long if it's not to her liking. You have to be committed.

2. WHAT HOURS ARE YOU WORKING?

I work from 7:00 a.m. to 3:00 p.m.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes! I am not a night time person. I don't function very well.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Well, I raised four children and need to be needed. This is the unit that I function best in because it affords me a challenge and I look forward to coming to work each day. I sometimes feel in a spiritual sense that I am being rewarded monetarily but also I need something besides the money. I need the gratification that I helped someone feel a little bit better or I made them a little more comfortable.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

Well, it's maybe the patient's situation. If it is a young person, I feel more stress than it is is someone who has been holding on to life for a long time. I always try to have my patients as comfortable and looking as good as I can before the families come in. Their reactions to the loved one in this area can be stressful.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

We have a support group in I.C.U. with a great leader. She takes up where we sometimes can't go. She works with us and then extends out to the family to be of assistance. She is kind of a go-between.

I have some hobbies that help when I go home. But, sometimes I just go home and prepare a meal and say, 'I'm not going to do a darn thing today.' Would you believe my Christmas tree is still up? I live alone and I just don't push myself anymore.

INTERVIEW 12

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am in a medical/surgical unit.

IS THIS THE UNIT OF YOUR CHOICE?

Yes, for right now. I have worked other units but this is a good unit for me right now.

2. WHAT HOURS ARE YOU WORKING?

7:00 a.m. to 3:00 p.m.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes, because of my children.

WHY DO YOU PREFER THIS SHIFT?

It is important for me to spend as much time with my children as possible and this shift allows me to do so.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Yes. My husband just died seven months ago and I did not want to work Intensive Care. I had not worked for two years and I came back three months ago.

HOW IMPORTANT WAS THIS FACTOR IN YOUR CHOICE?

Extremely important to me in my life right now.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

It becomes stressful for each of us when we are short of help and we don't have time to get everything done that needs to be done for the patient. This happens occasionally, not often. This floor is pretty well staffed and everybody is a good worker. We are self-contained so we don't have to worry about that too much, but that is very traumatic when you are on a unit where it does happen. The whole staff was moved at Christmas and we were glad to have that week over with. The patients did not even like it.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

When I become stressed on the job, I just automatically set my priorities and do what has to be done first. Then I do the things that aren't as important to patient care when I have the time.

At home I run and I read and I knit and I do fun things with my kids. I like to be outdoors. I am working very hard to manage the stress due to changes in my life. I think it is working.

INTERVIEW 13

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am in a medical/surgical unit. Non-Intensive Care.

IS THE THE UNIT OF YOUR CHOICE?

Yes. Although I would enjoy some other units as long as it was not Intensive Care.

2. WHAT HOURS ARE YOU WORKING?

7-3.

ARE YOU WORKING THE HOURS OF YOUR CHOICE?

I prefer this shift. I have 18 years of night duty and that is why I am here in this position.

WHY DO YOU PREFER THIS SHIFT?

Who wouldn't? After 18 years, I took this position to become a day person again.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

I have had critical care in my past experience and I am not anxious to be in a place where patients are critical all the time. I have benefited from this experience and I am glad for what I have but I do not want to go back. I have been in primary nursing care for 35 years and I am ready for this type of a unit.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

About the only thing that stresses me is too heavy a work load, not getting to do everything I want to do for my patients. You just have to do the most important things and set your priorities.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I never carry my work home. Always through the years I just leave work at work and home at home. I manage better that way. I have really learned to really not take offense at anything. If someone wants to take offense at me, they have to tell me they are taking offense; otherwise, I just go about my business. I take care of my patients and help the other nurses if they need help and they ask me. I am not really one to bridge over into their business unless they want help. This is the easiest nursing job I have ever had.

INTERVIEW 14

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am working Critical Care.

IS THIS THE UNIT OF YOUR CHOICE?

At this time it is where I feel I can be the most beneficial.

2. WHAT HOURS ARE YOU WORKING?

I work two shifts at times, but my regular shift is 11-7.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes. I like the type of care we give these patients on the night shift.

WHY DO YOU PREFER THIS SHIFT?

Of all the shifts this one suits my needs and gives me the greatest satisfaction. These patients often cannot sleep and I enjoy spending quality nursing time with them at night.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

I just had an interest in coronary care experience, one that I had never had before. I have come to enjoy this experience and really like to work with coronary care patients. Everything associated with coronary care patients is so specialized that it has just become my first love. That is the number one medical problem in the United States.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

I think long-term patients that we have for weeks and weeks at a time. They don't seem to get any better. I wonder what we as nurses could do in conjunction with what the doctor is doing, maybe to speed up their recovery. It bothers me when I come back week after week and that same patient is still there and there is no significant change. It is very frustrating and stressful. It really bothers me to see the ones with bright, alert eyes go down as they stay in the unit. As time passes the condition slowly deteriorates. What can we do to save that patient that we are not doing? What could we have done when they first came in to prevent their going down hill.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I don't know if I handle stress well. Usually talking about it either with my coworkers or with my husband when I go home. I can feel when I am stressed out and I start moving fast and doing things fast and I get irritable; I start talking to myself. I just say 'slow down, you know what happened the last time

INTERVIEW 14 (Continued)

this happened, you cut your finger real bad.' I will get the job done better if I will allow myself to slow down. Talking it out with somebody is the best for me. I practice some breathing techiques that help when I can't sleep at night. These help me to relax. As I said, 'I don't know if I handle stress well or not.'

INTERVIEW 15

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am in the Acute Coronary Care Unit.

IS THIS THE UNIT OF YOUR CHOICE?

I would have liked the Emergency Room but I had worked here before so this really was the unit of choice.

2. WHAT HOURS ARE YOU WORKING?

The 7-3 shift.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Oh yes! I just don't function as well in the other shifts. Is that a sign of something?

WHY DO YOU PREFER THIS SHIFT?

I left another hospital to come here because I was burned out on nights. I couldn't sleep, you know. I also worked 18 months without a vacation. That did not help. If I had gotten days I would be probably still at that hospital.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

Yes, because I feel that I can accomplish more here. I feel that I get more self-satisfaction, possibly, than constantly running up and down halls and passing water to patients--well, that's not for me. I could do that for a change--for one day--but if I have to do it constantly, well, I just wouldn't be there. I would have to leave because it would just get boring. I guess I have to have that unexpectedness.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

My own feeling of inadequacy will create my stress. If I am unfamiliar with things and I am not shy about asking, I don't think to myself that I should feel terribly stupid for asking. That doesn't bother me, I ask. I feel that you have to cover all bases. If you are running around acting like you know everything, you are not doing that patient a bit of good. If you can ask somebody those important patient care questions, then it shows you are human like everyone else.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I talk to myself. I run through things and sometimes I just talk out loud. I do talk to myself. I have always talked to myself from the time I was a child. A psychiatrist told me recently, here in the hospital's cafeteria line, that talking to yourself is a healthy sign. I have good communication with

INTERVIEW 15 (Continued)

myself. But I don't answer myself back. I don't talk to myself when I leave here. When I leave here, that's it. I try to forget what's here when I leave and I pick it up when I return. At home, that's another life. You live two lives. You live one here and one at home. The secret to managing your stress is to keep them separated.

INTERVIEW 16

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

I am in critical care at this time.

IS THIS THE UNIT OF YOUR CHOICE?

I would like to say yes, but I am in the process of changing to the new Neonatal I.C.U. I move to that unit in three weeks. I have been in this particular unit for five years and I have enjoyed it, but I do need a change. It has been my first choice for these five years. I am looking forward to the change. I haven't been excited in a long time. I have been reading and walking by the Nursery and staring and thinking that I will soon be there. I'm going to enjoy it, I think.

2. WHAT HOURS ARE YOU WORKING?

3-11 shift.

ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

Yes.

WHY DO YOU PREFER THIS SHIFT?

At the moment it works out well. I have a small son and that way I don't have to leave him at the baby sitter very long. My husband picks him up and cares for him in the evening.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

What made me make a change to neonatal care was that I was burned out. I wanted to stay in the critical area and working with babies sounds like more of a challenge to me. I have not learned all the possible information in this unit. I know that I could advance in this unit but I am not interested. I need to grow and to change. When there is plenty of opportunity to grow and you don't continue to grow, it's time to get out. The thing that keeps me in critical care areas is that I feel that you can give better patient care and the staffing is usually such that you can. I don't have to worry about 10 patients, I just have 2 or 3 at the most and I feel like I can do a good job.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

The main thing which we do not get very often are the balloon patients. Those are very stressful for me because I have never had the opportunity to go to an in-service on them. I am always afraid the pump is going to run out of helium or something and I am not going to know what to do. There are people around the unit who do know what to do. There is always a resource person.

INTERVIEW 16 (Continued)

We did have staffing problems. If you notice the acuity board today, one nurse has four patients. In a critical care area, in the back of my mind, I think that is not good. That bothers me. Right now the unit is budget conscious and at our last meeting they are talking about not hiring any more people. We will have to work harder and that is alright, except they are not thinking about the patient. Administrative people get on my case a lot. They are not patient-oriented. I am a bedside nurse.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

I keep busy. I don't dwell on things. It doesn't help to dwell on things. I usually can go to bed when I get home unless I am really upset, which isn't too often. Things don't stress me a whole lot any more. I guess I ignore it. I ventilate to peers some. That helps. I think we all do that. I don't jog or meditate and I'm not religious. I just stay busy at home and don't think about work until it is time to come to work. I have been known to call on weekends to see if a patient is still there. Just kind of out of curiosity. I sometimes hope that he would not be. Suffering bothers me but I try not to dwell on it. I just go about my business and do the best I can because there is usually nothing you can do to change the situation. One nice thing to look forward to is your turn on the remote monitor. If you have had a real stressful 2 or 3 days on the floor, you look forward to being on remotes next time you come in. Remote monitors have their own stress factors but I look forward to that break in the routine.

INTERVIEW 17

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

   In a medical unit.

   IS THIS THE UNIT OF YOUR CHOICE?

   Yes, for the present time. I enjoy the nature of the illnesses more than on some other units and I am satisfied at the present.

2. WHAT HOURS ARE YOUR WORKING?

   3-11.

   ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

   Not really, but to get this duty I can work this for a while.

   WHICH SHIFT DO YOU PREFER?

   I would really prefer to be a regular on the 7-3 day shift. I don't like to tackle that parking lot at night.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

   Yes. In my case it was a big decision. I did not want the stresses of some units I could have gone to. I like it here.

   HOW IMPORTANT WAS THE FACTOR IN YOUR CHOICE?

   It was important enough to me to take a shift that I do not prefer in order to work in this unit.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

   Getting off at 11:00 p.m. and going to the parking lot alone. I wait for the security guard or for several other nurses to come along before venturing through the parking area. This unit is well run and we get along well with each other. Occasionally a visitor or family member will create a problem, but we resolve it quickly. We do not see too much of the doctors on the last half of the shift. If there is some tension there, I try to relieve it with a little light hearted joke. I really have few stressors on the job. I think I have learned to handle them.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

   I have learned to meditate. This is the most calming thing I have learned to do for myself. Occasionally, I share the technique with others. It is so sensible a way to slow the pace and learn to cope. I also take B12, E and Lecithin. Stress is not so much a factor in my life since I found the answer for me. I don't really need another stress management technique.

INTERVIEW 18

1. IN WHICH UNIT ARE YOU PRESENTLY WORKING?

   This is a med/surg floor.

   IS THIS THE UNIT OF YOUR CHOICE?

   Yes, for now. I always like a challenge and may change later. I am satisfied with my nursing duties at this time.

2. WHAT HOURS ARE YOU WORKING?

   11:00 p.m. to 7:00 a.m.

   ARE YOU WORKING THE SHIFT OF YOUR CHOICE?

   I don't mind this shift. It is quiet most of the night. Some nights seem to go a little slow when we are not so very busy. I guess I like it fine. I don't get up well in the early morning. I do like the 3-11 shift, also.

   WHY DO YOU PREFER THIS SHIFT?

   Families and visitors are rarely here on this shift. We get our work done with greater ease. I do well at night and I like the night duties. The nurses I work with are easy to get along with and I look forward to coming to work most nights.

3. WAS THE NATURE OF THE PATIENT ILLNESS OR THE POSSIBILITY OF SERIOUS COMPLICATIONS OR DEATH A MAJOR FACTOR IN YOUR CHOICE OF HOSPITAL UNITS?

   Not too much of a factor. I like it fine for now. I might like to go to a critical care area if I could be on the 3-11 shift. There are few openings now. A year ago you had more of a choice of shift and unit. So many nurses have come back to work since the economic crunch. I just decided to stay where I am for now.

4. WHAT FACTORS OF YOUR JOB DO YOU FEEL CREATE THE MOST STRESS FOR YOU?

   Coffee! Nurses drink tons of coffee. I really do need to cut down. Seriously, I have found few stressors on this shift. Our Head Nurse is excellent. She keeps things humming around here 24 hours a day. We don't see her as often on this shift but I really appreciate the job she does in this unit. I think she helps to get the stress under control just by her attitude toward the important things we have to deal with.

5. WHAT METHODS OF STRESS MANAGEMENT HAVE YOU FOUND PERSONALLY HELPFUL IN DEALING WITH YOUR OWN STRESS ON THE JOB?

   I just take a real deep breath and relax. I run in the mornings when the weather permits. This really seems to help relieve the tension and stress. I don't feel that I suffer much from extreme stress but I know it exists all the time. I feel that if you are aware of its presence, you can deal with it as

INTERVIEW 18 (Continued)

it comes along. We are able to communicate well with each other here on the unit. We vent our gripes and frustrations and that helps. I just do my job. I try to make it meaningful while I am here. When I go home I usually don't think about work til it's time to come back. It works for me, anyway.

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Demographic Questionnaire

1. Age: 20's __ 30's __ 40's __ 50's __ 60's __

2. Sex: M F (circle one)

3. Race: Black Caucasian Hispanic American Indian (circle one)
   Other: Specify _____

4. Highest diploma or degree completed (check one):

ASN Degree	__	MA/MS/MPH Degree	__
Nursing Diploma	__	Doctoral Degree	__
BA/BS/BSN Degree	__	Other: Specify	_____
LPN	__		

5. Marital status: Single __ Married __ Divorced __ Widowed __
   Other: Specify _____

6. Number of children: ___ Ages of children: _____

7. Spouse's occupation (if married): _____

8. Highest diploma or degree completed by spouse (if married):

High School Diploma	__	MA/MS Degree	__
BA/BS Degree	__	Doctoral Degree	__
AA Degree	__	Other: Specify	_____

9. Number of years you have been a nurse: ____

10. Present unit of employment within the hospital: _____
    _____

11. Size of unit of patient care (circle one):
    0-10 11-20 21 and over

12. Work shift (circle one): 7-3 3-11 11-7 Other: _____

13. Number of professional in-service training courses you have had beyond your nursing education: ___

14. List any meaningful in-service training courses that have helped you manage stress? _____
    _____
    _____

APPENDIX D

INSTRUCTIONS FOR THE NURSING STRESS SCALE

The Nursing Stress Scale

On the following pages are a number of situations that commonly occur on a hospital unit. For each item decide how often in your present unit you have found the situation to be stressful. Indicate HOW OFTEN it is stressful by encircling the appropriate number on the 4-point scale. Then, decide the INTENSITY of the stress experienced by encircling the appropriate number on the 5-point scale.

FREQUENCY: How often is situation stressful?

Never	Occasionally	Frequently	Very Frequently
1	2	3	4

INTENSITY OF STRESS: How strong is the stress?

Never	Mild	Moderate	Major	Severe
1	2	3	4	5

EXAMPLE:

00. Watching a patient suffer.

HOW OFTEN: 1 (2) 3 4

HOW STRONG: 1 2 3 (4) 5

If watching a patient suffer is occasionally stressful (say a few times a month), you would encircle the number 2. If, when you experience stress, it is a fairly strong feeling but not as strong as you imagine, you would encircle the number 4.

APPENDIX E

THE NURSING STRESS SCALE

The Original Nursing Stress Scale, designed by Pamela Gray-Toft and James G. Anderson, which tests frequency of stress in hospital nurses appears in Appendix E in its entirety. The intensity of stress scale, as designed by the researcher, appears directly below the frequency scale on each of the thirty-four (34) items.

HOW OFTEN:	1	2	3	4
	Never	Occasionally	Frequently	Very Frequently

HOW STRONG:	1	2	3	4	5
	Never	Mild	Moderate	Major	Severe

1. Breakdown of computer and/or specialized equipment.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

2. Criticism by a physician.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

3. Performing Procedures that patients experience as painful.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

4. Feeling helpless in the case of a patient who fails to improve.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

5. Conflict with a supervisor.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

6. Listening or talking to a patient about his/her approaching death.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

7. Lack of an opportunity to talk with other unit personnel about problems on the unit.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

8. The death of a patient.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

9. Conflict with a physician.

   HOW OFTEN: 1 2 3 4
   HOW STRONG: 1 2 3 4 5

HOW OFTEN:	1	2	3	4
	Never	Occasionally	Frequently	Very Frequently

HOW STRONG:	1	2	3	4	5
	Never	Mild	Moderate	Major	Severe

10. Fear of making a mistake in treating a patient.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

11. Lack of an opportunity to share experiences and feelings with other personnel on the unit.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

12. The death of a patient with whom you developed a close relationship.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

13. Physician not being present when a patient dies.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

14. Disagreement concerning the treatment of a patient.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

15. Feeling inadequately prepared to help the emotional needs of a patient's family.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

16. Lack of an opportunity to express to other personnel on the unit my negative feelings toward patients.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

17. Inadequate information from a physician regarding the medical condition of a patient.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

HOW OFTEN: 1 Never 2 Occasionally 3 Frequently 4 Very Frequently

HOW STRONG: 1 Never 2 Mild 3 Moderate 4 Major 5 Severe

18. Being asked a question by a patient for which I do not have a satisfactory answer.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

19. Making a decision concerning the patient when the physician is unavailable.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

20. Floating to other units that are short-staffed.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

21. Watching a patient suffer.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

22. Difficulty in working with a particular nurse (or nurses) outside the unit.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

23. Feeling inadequately prepared to help with the emotional needs of a patient.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

24. Criticism by a supervisor.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

25. Unpredictable staffing and scheduling.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

HOW OFTEN:	1	2	3	4
	Never	Occasionally	Frequently	Very Frequently

HOW STRONG:	1	2	3	4	5
	Never	Mild	Moderate	Major	Severe

26. A physician ordering what appears to be inappropriate treatment for a patient.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

27. Too many nonnursing tasks required, such as clerical work.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

28. Not enough time to provide emotional support to a patient.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

29. Difficulty in working with a particular nurse (or nurses) on the unit.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

30. Not enough time to complete all of my nursing tasks.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

31. A physician not being present in a medical emergency.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

32. Not knowing what a patient or a patient's family ought to be told about the patient's condition and its treatment.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

33. Uncertainty regarding the operation and functioning of specialized equipment.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

34. Not enough staff to adequately cover the unit.

HOW OFTEN: 1 2 3 4
HOW STRONG: 1 2 3 4 5

APPENDIX F

HOSPITAL CONSENT FORMS

Consent Form

I, _____ (subject), voluntarily consent to participate in the study entitled "A Study of Occupational Stress in Selected Specialties in the Nursing Profession" and understand:

The following questionnaire and 34-item Nursing Stress Scale are designed to be the major methodological portion of a doctoral dissertation to be granted jointly by the Departments of Higher Education and Health, Physical Education and Leisure Services at Oklahoma State University to Carol M. Parker this spring.

The Nursing Stress Scale attempts to indicate the frequency and intensity of stress in 34 potentially stressful situations. In this study critical and non-critical care nurses will be asked to respond to the questionnaire and the Nursing Stress Scale in order to measure the differences, if any exist, between the stress levels of critical care and non-critical care nurses while on duty in the hospital. All information gained in this study will be treated with strictest confidentiality.

I am grateful for your participation in this study.

Carol M. Parker

Carol M. Parker
Researcher

Mercy Health Center
December, 1982

Consent Form

I, _____ (subject), voluntarily consent to participate in the study entitled "A Study of Occupational Stress in Selected Specialties in the Nursing Profession," and understand:

The following questionnaire and 34-item Nursing Stress Scale are designed to be the major methodological portion of a doctoral dissertation to be granted jointly by the Departments of Higher Education and Health, Physical Education and Leisure Services at Oklahoma State University to Carol M. Parker this spring.

The Nursing Stress Scale attempts to indicate the frequency and intensity of stress in 34 potentially stressful situations. In this study critical and non-critical care nurses will be asked to respond to the questionnaire and the Nursing Stress Scale in order to measure the differences, if any exist, between the stress levels of critical care and non-critical care nurses while on duty in the hospital. All information gained in this study will be treated with strictest confidentiality.

I am grateful for your participation in this study.

Carol M. Parker

Carol M. Parker
Researcher

Baptist Medical Center

I, _____ (Subject), voluntarily consent to participate in the study entitled "A Study of Occupational Stress in Selected Specialties in the Nursing Profession," by Carol M. Parker, investigator, and understand:

1. The purpose of the research is to study the intensity and frequency of stress in hospital nurses. A comparison of stress factors in the critical and non-critical care nurse will be made in order to measure any differences that might exist regarding intensity and frequency.

2. The study consists of a 14-item demographic questionnaire and a 34-item Nursing Stress Scale, both of which can be administered in approximately 10 minutes. Two nurses from each shift will be asked to answer five interview questions concerning their perceptions of on-the-job stressors. Each interview session can be accomplished in less than 10 minutes. No other time or procedure will be requested.

3. There is no direct benefit to the participating subject other than the realization that research is being furthered in the area of stress in the hospital nurse as a result of participation in this study. The results will be shared with those who participate.

4. There are no known risks. There might be a slight inconvenience due to the 10 minutes it will take to respond to the questionnaire and Nursing Stress Scale or to the interview.

5. Throughout the study every effort will be exerted to maintain and protect the anonymity of each participant on the questionnaires or the interviews.

_____ _____
Date Signature of Research Subject

_____ _____
Date Signature of Investigator

Presbyterian Hospital
January, 1983

VITA

Carol M. Parker

Candidate for the Degree of

Doctor of Education

Thesis: A STUDY OF OCCUPATIONAL STRESS IN SELECTED SPECIALTIES IN THE NURSING PROFESSION

Major Field: Higher Education

Minor Field: Health, Physical Education, and Recreation

Biographical:

Personal Data: Born in Oklahoma City, Oklahoma, December 15, 1940, the daughter of Mr. and Mrs. Warren W. Wall; married to Dr. William D. Parker; one son, Daniel Warren Parker.

Education: Graduated from Will Rogers High School, Tulsa, Oklahoma, in 1958; received the Bachelor of Science degree in Health, Physical Education, and Recreation from the University of Tulsa, Tulsa, Oklahoma, in 1966; received the Master of Education degree in Health, Physical Education and Safety from Northeastern Oklahoma State University, Tahlequah, Oklahoma, in 1970; postmaster in Public Health at the University of Oklahoma Health Sciences Center during the summer and fall of 1976; completed requirements for the Doctor of Education degree at Oklahoma State University in May, 1983.

Professional Experience: Health teacher at Tahlequah Junior High School, Tahlequah, Oklahoma, 1966-68; Health and Physical Education teacher at DuVal High School, Glenn Dale, Maryland, 1968-69; Instructor of Health, Physical Education and Recreation at Central State University, Edmond, Oklahoma, 1970-1975; Assistant Professor and Coordinator of Community Health Degree Program at Central State University, 1975-1983.